

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG210 2-11-57 et

CERTIFICATE OF DEATH

01924

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home				d. STREET ADDRESS 12211 Connecticut Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Esther Middle Abrams Last				4. DATE OF DEATH Month Feb. Day 1 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1888		9. AGE (In years last birthday) yrs. 69	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Cantor				14. MOTHER'S MAIDEN NAME Sarah			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. George Pikser		Address Daughter	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Atherosclerosis DUE TO (c) unknown						INTERVAL BETWEEN ONSET AND DEATH 10 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) myocardial infarction - convalescent						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/3 , 19 56 , to 2/1 , 19 57 , that I last saw the deceased alive on 1/25 , 19 57 , and that death occurred at 1 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3900 McKinley St. N.W. DATE SIGNED 2/1/57 ACTUAL SIGNATURE Irving W. Winik M.D. Washington 15, D.C. PHYSICIAN'S NAME (Type) Irving W. Winik							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/1/57		22c. NAME OF CEMETERY OR CREMATORY National Capitol Hebrew		22d. LOCATION (City, town, or county) (State) Wash., D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons				ADDRESS 3501 14th St., N. W.		24a. REC'D BY REGISTRAR DATE 2-2-57	
				24b. REGISTRAR'S SIGNATURE Bernard M. Danzansky			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MAINTAINING STATE DEPARTMENT OF HEALTH - DIVISION OF VITAL RECORDS

<p>1. Name of deceased [Illegible]</p>		<p>2. Sex [Illegible]</p>	
<p>3. Date of birth [Illegible]</p>		<p>4. Place of birth [Illegible]</p>	
<p>5. Date of death [Illegible]</p>		<p>6. Place of death [Illegible]</p>	
<p>7. Cause of death [Illegible]</p>		<p>8. Manner of death [Illegible]</p>	
<p>9. Signature of physician [Illegible]</p>		<p>10. Signature of registrar [Illegible]</p>	
<p>11. Signature of informant [Illegible]</p>		<p>12. Signature of witness [Illegible]</p>	
<p>13. Signature of registrar [Illegible]</p>		<p>14. Signature of registrar [Illegible]</p>	
<p>15. Signature of registrar [Illegible]</p>		<p>16. Signature of registrar [Illegible]</p>	
<p>17. Signature of registrar [Illegible]</p>		<p>18. Signature of registrar [Illegible]</p>	
<p>19. Signature of registrar [Illegible]</p>		<p>20. Signature of registrar [Illegible]</p>	
<p>21. Signature of registrar [Illegible]</p>		<p>22. Signature of registrar [Illegible]</p>	
<p>23. Signature of registrar [Illegible]</p>		<p>24. Signature of registrar [Illegible]</p>	
<p>25. Signature of registrar [Illegible]</p>		<p>26. Signature of registrar [Illegible]</p>	
<p>27. Signature of registrar [Illegible]</p>		<p>28. Signature of registrar [Illegible]</p>	
<p>29. Signature of registrar [Illegible]</p>		<p>30. Signature of registrar [Illegible]</p>	
<p>31. Signature of registrar [Illegible]</p>		<p>32. Signature of registrar [Illegible]</p>	
<p>33. Signature of registrar [Illegible]</p>		<p>34. Signature of registrar [Illegible]</p>	
<p>35. Signature of registrar [Illegible]</p>		<p>36. Signature of registrar [Illegible]</p>	
<p>37. Signature of registrar [Illegible]</p>		<p>38. Signature of registrar [Illegible]</p>	
<p>39. Signature of registrar [Illegible]</p>		<p>40. Signature of registrar [Illegible]</p>	
<p>41. Signature of registrar [Illegible]</p>		<p>42. Signature of registrar [Illegible]</p>	
<p>43. Signature of registrar [Illegible]</p>		<p>44. Signature of registrar [Illegible]</p>	
<p>45. Signature of registrar [Illegible]</p>		<p>46. Signature of registrar [Illegible]</p>	
<p>47. Signature of registrar [Illegible]</p>		<p>48. Signature of registrar [Illegible]</p>	
<p>49. Signature of registrar [Illegible]</p>		<p>50. Signature of registrar [Illegible]</p>	
<p>51. Signature of registrar [Illegible]</p>		<p>52. Signature of registrar [Illegible]</p>	
<p>53. Signature of registrar [Illegible]</p>		<p>54. Signature of registrar [Illegible]</p>	
<p>55. Signature of registrar [Illegible]</p>		<p>56. Signature of registrar [Illegible]</p>	
<p>57. Signature of registrar [Illegible]</p>		<p>58. Signature of registrar [Illegible]</p>	
<p>59. Signature of registrar [Illegible]</p>		<p>60. Signature of registrar [Illegible]</p>	
<p>61. Signature of registrar [Illegible]</p>		<p>62. Signature of registrar [Illegible]</p>	
<p>63. Signature of registrar [Illegible]</p>		<p>64. Signature of registrar [Illegible]</p>	
<p>65. Signature of registrar [Illegible]</p>		<p>66. Signature of registrar [Illegible]</p>	
<p>67. Signature of registrar [Illegible]</p>		<p>68. Signature of registrar [Illegible]</p>	
<p>69. Signature of registrar [Illegible]</p>		<p>70. Signature of registrar [Illegible]</p>	
<p>71. Signature of registrar [Illegible]</p>		<p>72. Signature of registrar [Illegible]</p>	
<p>73. Signature of registrar [Illegible]</p>		<p>74. Signature of registrar [Illegible]</p>	
<p>75. Signature of registrar [Illegible]</p>		<p>76. Signature of registrar [Illegible]</p>	
<p>77. Signature of registrar [Illegible]</p>		<p>78. Signature of registrar [Illegible]</p>	
<p>79. Signature of registrar [Illegible]</p>		<p>80. Signature of registrar [Illegible]</p>	
<p>81. Signature of registrar [Illegible]</p>		<p>82. Signature of registrar [Illegible]</p>	
<p>83. Signature of registrar [Illegible]</p>		<p>84. Signature of registrar [Illegible]</p>	
<p>85. Signature of registrar [Illegible]</p>		<p>86. Signature of registrar [Illegible]</p>	
<p>87. Signature of registrar [Illegible]</p>		<p>88. Signature of registrar [Illegible]</p>	
<p>89. Signature of registrar [Illegible]</p>		<p>90. Signature of registrar [Illegible]</p>	
<p>91. Signature of registrar [Illegible]</p>		<p>92. Signature of registrar [Illegible]</p>	
<p>93. Signature of registrar [Illegible]</p>		<p>94. Signature of registrar [Illegible]</p>	
<p>95. Signature of registrar [Illegible]</p>		<p>96. Signature of registrar [Illegible]</p>	
<p>97. Signature of registrar [Illegible]</p>		<p>98. Signature of registrar [Illegible]</p>	
<p>99. Signature of registrar [Illegible]</p>		<p>100. Signature of registrar [Illegible]</p>	

BUREAU V. 2

FEB 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 21 Film 0211 2-25-57 et

1932

CERTIFICATE OF DEATH

01925

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Fairfax</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>67 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Albert</u> Last <u>Arnold</u>				4. DATE OF DEATH Month <u>February</u> Day <u>17</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>7 December 1897</u>	9. AGE (In years last birthday) yrs. <u>59</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assistant Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dairy</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Berton Arnold</u>				14. MOTHER'S MAIDEN NAME <u>Nellie Horner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Not available</u>		17. INFORMANT Address <u>The Medical Record, Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause for line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Esophagus</u> <u>150X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month _____ Day _____ Year _____		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>December 12, 19 57</u> to <u>February 17, 19 57</u> , that I last saw the deceased alive on <u>February 17, 19 57</u> , and that death occurred at <u>3.50 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard R. Engel</u> M.D.				ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>2/17/57</u>			
PHYSICIAN'S NAME (Type) <u>Howard R. Engel, M.D.</u>				The Clinical Center National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 20, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) _____ (State) _____ <u>Bladensburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Mountcastle</u> ADDRESS <u>Cunningham Funeral Home, Inc., Alexandria, Va.</u>				24a. REC'D BY REGISTRAR DATE <u>2-20-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

CERTIFICATE OF DEATH

STATE OF MARYLAND

FILE NO.

DATE

TIME

PLACE

CAUSE

MANNER

AGE

SEX

RACE

RELIGION

OCCUPATION

EDUCATION

RESIDENCE

DATE OF BIRTH

DATE OF DEATH

DATE OF BURIAL

DATE OF CREMATION

DATE OF INTERMENT

DATE OF REINTERMENT

BUREAU V. S.

FEB 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG210 2-11-57 et

1933

CERTIFICATE OF DEATH

Reg. Dist. No.

019226
276

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>7 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>WALTER</u> First <u>Edward</u> Middle <u>Ayers, Sr.</u> Last				4. DATE OF DEATH <u>2-2</u> Month <u>2</u> Day <u>2</u> Year <u>1954</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2 April 1884</u> 1874	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Bedford County, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Thomas J. Ayers</u>				14. MOTHER'S MAIDEN NAME <u>Anna Ashwell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Walter E. Ayers, Jr. - Silver Spring, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>432.0</u> (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>31 Jan</u> 1957, to <u>42 Feb</u> 1957, that I last saw the deceased alive on <u>2 Feb</u> 1957, and that death occurred at <u>278</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7 Crothers Court, Rock Md</u> DATE SIGNED <u>2/2/57</u>							
ACTUAL SIGNATURE <u>Herman C. Maganzini</u> M.D.				PHYSICIAN'S NAME (Type) <u>Herman C. Maganzini</u> <u>7 Crothers Ct Rockville Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 5, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Roanoke, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. D. Kump - Bethesda Md.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>2-5-57</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

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THE STATE DEPARTMENT OF HEALTH

1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

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BUREAU V. S.

7 FEB 7 1957

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1934

CERTIFICATE OF DEATH

Reg. Dist. No.

1927
(01927)

1. PLACE OF DEATH <u>Kensington Gardens</u> a. COUNTY <u>Montgomery</u> <u>Kensington</u> , MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D. C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b <u>10 mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Nursing Home</u>				d. STREET ADDRESS <u>5 Pinehurst Circle, N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frederick</u> Middle <u>J.</u> Last <u>Bailey</u>				4. DATE OF DEATH Month <u>February</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 19, 1878</u>		9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Government</u>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Albert H. Bailey</u>				14. MOTHER'S MAIDEN NAME <u>Adele Buchanan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Gilman Bailey-5 Pinehurst Circle Chevy Chase, D.C.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia (Terminal)</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular-renal Disease</u> DUE TO <u>Total paralysis, left leg and left arm</u> (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>7 years</u> <u>7 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u> </u> m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 1, 1954</u> to <u>Feb. 26, 1957</u> , that I last saw the deceased alive on <u>Feb. 26, 1957</u> , and that death occurred at <u>5 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edw. A. Krause</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>3805 McKinley St., N.W.</u> <u>2/26/57</u> <u>Washington 15, D. C.</u>			
PHYSICIAN'S NAME (Type) <u>Edward A. Krause</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		22b. DATE THEREOF <u>2/28/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co. Washington, D. C.</u>				ADDRESS <u> </u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>FEB 28 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Frances Pattery</u>			

CERTIFICATE OF DEATH

BUREAU V. S.

FEB 28 1957

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1935 CERTIFICATE OF DEATH

01928

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 3 Days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.			d. STREET ADDRESS Qtrs. "B", Navy Gun Factory		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Josebio Mundo BAINCO			4. DATE OF DEATH Month February Day 10 Year 19 57		
5. SEX Male	6. COLOR OR RACE Malayan	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 Feb. 1957		9. AGE (In years lost birthday) yrs. 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nonen		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Bethesda, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME Eusebio (n) Bainco			14. MOTHER'S MAIDEN NAME Josefina Mundo		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (Father) Eusebio Bainco (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGENITAL ATELECTASIS DUE TO 762.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PREMATURITY DUE TO (c) 72 hrs.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 7 Feb. , 19 57 , to 10 Feb. , 19 57 , that I last saw the deceased alive on 10 Feb. , 19 57 , and that death occurred at 1:45 A.M. , from the causes and on the date stated above.					
ACTUAL SIGNATURE Daniel Shuptar		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 2-11-57			
PHYSICIAN'S NAME (Type) Daniel Shuptar, LT, MC, USN		ADDRESS U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-12-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery	
22d. LOCATION (City, town, or county) Arlington, Virginia		22e. (State) Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey		ADDRESS 5557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR 2-11-57	
24b. REGISTRAR'S SIGNATURE Mary E. Russell					

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CERTIFICATE OF DEATH

BUREAU V. S.

FEB. 13. 1957

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1936 CERTIFICATE OF DEATH

01929
215

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 80 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Andrew Middle (nmn) Last BANYAS				4. DATE OF DEATH Month February Day 19 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH August 5, 1934	9. AGE (In years last birthday) 22 yrs.	IF UNDER 1 YEAR Months 22 Days 22 Hours 22 Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Andrew Banyas				14. MOTHER'S MAIDEN NAME Elsie Drango			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Currently		17. INFORMANT (Mother) Mrs. Elsie R. Schwerha (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Seminoma of right testis with DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastases to regional nodes and abdominal DUE TO (c) and thoracic viscera.							INTERVAL BETWEEN ONSET AND DEATH 8-12 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. ft. Month, Day, Year 19 p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County) (State)		
21. I certify that I attended the deceased from 1 Dec. , 19 56 to 19 Feb. , 19 57 , that I last saw the deceased alive on 19 Feb. , 19 57 , and that death occurred at 7:55 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 2-19-57							
ACTUAL SIGNATURE Byron D. Casteel M.D. U.S. Naval Hospital, Bethesda, Md.							
PHYSICIAN'S NAME (Type) BYRON D. CASTEEL, CAPT, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-23-57		22c. NAME OF CEMETERY OR CREMATORY Braddock Catholic Cemetery		22d. LOCATION (City, town, or county) (State) Braddock, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey, 7557 Wisconsin Ave., Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 2-20-57		24b. REGISTRAR'S SIGNATURE Harry E. Passelty	

RECEIVED

FEB 25 1957

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1910

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>16 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>				d STREET ADDRESS <u>Briggs-Chaney Road</u>			
3 NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Eugenia</u> Last <u>Barker</u>				4. DATE OF DEATH Month <u>2</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 8 - 1873</u> 9 AGE (In years last birthday) <u>82 yrs.</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Music teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed-ret</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Porter</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Boatwright</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>Unknown</u>		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>33dX</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral Common Iliac Embolism, Atherosclerotic</u>						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>August</u> 19 <u>55</u> , to <u>Feb. 21</u> 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 21</u> 19 <u>57</u> , and that death occurred at <u>4:55 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>J. M. Whitlock</u> M.D. <u>7600 Carroll Ave. Takoma P, Md - 27 57</u> PHYSICIAN'S NAME (Type) <u>J. M. Whitlock, M.D.</u> <u>7600 Carroll Avenue, Takoma Park, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-transit</u>		22b. DATE THEREOF <u>2/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cem. Inc.</u>		22d. LOCATION (City, town, or county) _____ (State) _____ <u>Sullivan Co. (Bristol) Tennessee</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert D. Conroy</u>				ADDRESS <u>7557 Wis. Ave. Bethesda, Md</u>		24a. REC'D BY REGISTRAR <u>Feb 23 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. M. Whitlock</u>			

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BUREAU V. S.

FEB 27 1937

RECEIVED

1937 CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. LENGTH OF STAY IN 1b <u>9-8-56-2-11-57</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington GARDENS SANATORIUM</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
f. STREET ADDRESS <u>3000 McComas Street</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CORA</u> Middle <u>EMMA</u> Last <u>Bastable</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 22 - 1872</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>York, Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Gilbert Leber</u>		14. MOTHER'S MAIDEN NAME <u>Emma B. Bubaker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Tel. no. or unknown) <u>--</u> (If yes, give war or dates of service) <u>--</u>		16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT <u>G. C. Kindig- 11604 Viers Mill Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerotic Cardio-vascular disease</u> years. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Jan.</u> 1954, to <u>Feb. 11</u> 1957, that I last saw the deceased alive on <u>Feb. 10</u> 1957, and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Russell M. Tilley, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>4701 - Mass. Ave. N.W.</u> DATE SIGNED <u>2-11-57</u>			
PHYSICIAN'S NAME (Type) <u>Russell M. Tilley, Jr.</u>				<u>Wash. D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/14/57</u>		<u>Cedar Hill Cemetery</u>		<u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McS. H. Niner Co.</u> ADDRESS <u>2901-14th St. N.W.</u>				24a. REC'D BY REGISTRAR <u>DATE 2/14/57</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Frances Potter</u>	
						<u>W</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 A OVER 10



1938 CERTIFICATE OF DEATH

Reg. Dist. No. *24*

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a STATE Virginia b COUNTY Alexandria	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c LENGTH OF STAY IN 1b 81 days	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e STREET ADDRESS 39 Ansell Street	
3. NAME OF DECEASED (Type or print) First Robert Middle Frederick Last Batchelor		4 DATE OF DEATH Month February Day 25 , Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24, 1920
9. AGE (In years last birthday) 36 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Veterinarian		10b. KIND OF BUSINESS OR INDUSTRY Food & Drug (Gov't)	
11 BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Alfred Batchelor		14 MOTHER'S MAIDEN NAME Jeanette Williams	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		16 SOCIAL SECURITY NO 284-16-4726	
17 INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkins Disease with involvement 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) of lungs, spleen and lymph nodes DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 6, 1956 to February 25, 1957 , that I last saw the deceased alive on February 25, 1957 , and that death occurred at 3:45 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE James R. Stabenau M.D. M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) James R. Stabenau, M.D.		DATE SIGNED 2/25/57	
22a. BURIAL CREMATION, REMOVAL (Specify) Repos	22b. DATE THEREOF Feb 27, 1957	22c. NAME OF CEMETERY OR CREMATORY Isle of Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE C.P. Isaacson		ADDRESS Washington 1, D.C.	
24a. REC'D BY REGISTRAR 2-27-57		24b. REGISTRAR'S SIGNATURE Beane M. Thompson	

1. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

2. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 1 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01933

1939 CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>9810 Georgia Ave.</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Maple Lane Rest Home -9810 Ga. Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>SAMUEL</u> Middle <u>H.</u> Last <u>BATES</u>				4. DATE OF DEATH Month <u>FEB.</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/11/81</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>9</u> Hours <u>15</u> Min.		IF UNDER 24 HRS. Months <u>9</u> Days <u>9</u> Hours <u>15</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Government Printing Office</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Kentucky</u>		11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Thomas A. Bates</u>				14. MOTHER'S MAIDEN NAME <u>Mary Bates</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Flossie Bates-2926 Cortland Place N.W.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDITIS</u> <u>400.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <u>PARALYSIS AGITANS</u> DUE TO (c) <u>CHRONIC MYOCARDITIS</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC PROSTATITIS</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. 31</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>5206 Norwichey Dr.</u>	
20f. (City or town) <u>Chesapeake</u>				20g. (County) <u>Prince Georges Co.</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>JAN. 5</u> , 19 <u>57</u> , to <u>FEB. 9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>FEB. 9</u> , 19 <u>57</u> , and that death occurred at <u>8:12 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry H. Lowden</u> M.D.				ADDRESS (Street, city or town, state) <u>5206 Norwichey Dr.</u>			
PHYSICIAN'S NAME (Type) <u>HENRY H. LOWDEN M.D.</u>				DATE SIGNED <u>2/9/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>2/12/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Company</u>				ADDRESS <u>Washington, D.C.</u>		24a. REC'D BY REGISTRAR <u>FEB 21 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>			

BUREAU V. S.

FEB 21 1957

RECEIVED

1940 CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Browningsville				c. LENGTH OF STAY IN 1b years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. Monrovia				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Browningsville			
				d. STREET ADDRESS R.F.D. Monrovia			
3. NAME OF DECEASED (Type or print) First Louis Middle Imogene Last Beall				4. DATE OF DEATH Month February Day 4 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1876	9. AGE (In years last birthday) yrs. 80	IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min 10		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Kempton, Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James Poole				14. MOTHER'S MAIDEN NAME Mary M. Buxton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Miss Virgie B. Beall, Monrovia, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from July 10, 1953 to February 4, 1957 , that I last saw the deceased alive on February 2, 1957 , and that death occurred at 5:00 a.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE James P. Kerr				ADDRESS (Street, city or town, state) Damascus, Md.			
PHYSICIAN'S NAME (Type) James P. Kerr				DATE SIGNED 2/5/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 6, 1957		22c. NAME OF CEMETERY OR CREMATORY Bethesda Methodist		22d. LOCATION (City, town, or county) (State) Browningsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Chas L Moleworth				ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR DATE Feb. 5/57	
				24b. REGISTRAR'S SIGNATURE Lella W. Burdett			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB

RECEIVED

1911

CERTIFICATE OF DEATH

Reg. Dist. No.

773

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. LENGTH OF STAY IN 1b <u>22 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>712 Wayne ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Lucinda</u> Middle <u>Lilley</u> Last <u>Beck</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-1-69</u>	
9. AGE (In years last birthday) <u>87</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pennia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>John Schissler</u>				14. MOTHER'S MAIDEN NAME <u>Anna Lilley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Son in law - chart. (same)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>hypertensive type - trochyl heart</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 1, 1957</u> to <u>Feb 27, 1957</u> that I last saw the deceased alive on <u>Feb 27, 1957</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>J. M. Whitlock</u> M.D. <u>7701 Canall Ave</u> <u>2-27-57</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>J.M. Whitlock</u> <u>Takoma Park, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/1/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Mausoleum</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thos. J. Davis Co. 2901-14th St NW D.C.</u>				24a. REC'D BY REGISTRAR <u>1957</u>		24b. REGISTRAR'S SIGNATURE <u>J. Wilson Duddy</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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RECEIVED

MAR 1 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01936

1941

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 29 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Theresa Middle Ann Last BERGTHOLD				4. DATE OF DEATH Month February Day 6 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 July 1956		9. AGE (In years lost birthday) yrs 6 Months 20 Days 20 Hours 20 Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John I. Bergthold				14. MOTHER'S MAIDEN NAME Barbara J. Myers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address (Mother) Barbara J. Bergthold (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital Heart Disease (Transposition great vessels) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 6 mo 20 da. (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. 7 p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8 January , 19 57 , to 6 February , 19 57 , that I last saw the deceased alive on 6 February , 19 57 , and that death occurred at 4:10 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE James E. Mc Clenathan				ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 2-7-57			
PHYSICIAN'S NAME (Type) James E. Mc Clenathan, LCDR, MC, U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12 Feb. 1957		22c. NAME OF CEMETERY OR CREMATORY Private Cemetery		22d. LOCATION (City, town, or county) (State) Pittsfield, Illinois	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey				24a. REC'D BY REGISTRAR 2-7-57		24b. REGISTRAR'S SIGNATURE May E. Russell	

BUREAU V. S.

FEB 13 1957

RECEIVED

01937

1942

CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Norbeck		c. LENGTH OF STAY IN b 2 years		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Garrett Park		d. STREET ADDRESS 10902 Kenilworth Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN		First R.		Middle BIRD		Last		4. DATE OF DEATH Month Feb. Day 10, Year 1957			
5 SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 9, 1875		9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 10 Days 1 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist (retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Norwich, Conn			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Joseph Bird				14. MOTHER'S MAIDEN NAME Susan Clay							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Edward F. Cassidy		Address Garrett Park 10911 Stillwater Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c) 										INTERVAL BETWEEN ONSET AND DEATH 48 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from January 1955 , to Feb 8 , 1957, that I last saw the deceased alive on February 8 , 1957, and that death occurred at 8:20 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) WASHINGTON CLINIC DATE SIGNED 											
ACTUAL SIGNATURE Morton C. Creditor M.D. WASHINGTON CLINIC				PHYSICIAN'S NAME (Type) Dr. Morton C. Creditor WASHINGTON IS-DC							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/10/57		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln				22d. LOCATION (City, town, or county) (State) Prince George Co. Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey						ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE 2/12/57		24b. REGISTRAR'S SIGNATURE Robert B. Lawler	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 20 1957

BUREAU V. S.

1912

CERTIFICATE OF DEATH

Reg. Dist. No. 2 23

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>4153</u> b. COUNTY <u>WASHINGTON, DC</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TARCMA PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON, DC</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. SAN. & HOSP</u>				e. STREET ADDRESS <u>6313-16th St NW.</u>			
3. NAME OF DECEASED (Type or print) <u>BENJAMIN M. PODNICK</u>				4. DATE OF DEATH <u>FEB. 19- 1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY-1-1892</u>	9. AGE (In years last birthday) <u>64</u> yrs	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SAVING BANK</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ISAAC PODNICK</u>				14. MOTHER'S MAIDEN NAME <u>GOLDA BELA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>174-01-126</u>		17. INFORMANT <u>ATTILIE PODNICK - 6313-16th St NW.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Insufficiency</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 year - 3 years -</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Feb. 1956</u> , to <u>Feb. 19 1957</u> , that I last saw the deceased alive on <u>Feb. 18 1956</u> , and that death occurred at <u>7:52 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Samuel Dessoff</u> M.D.				ADDRESS (Street, city or town, state) <u>1302-18th St NW Wash 6, D.C</u>			
PHYSICIAN'S NAME (Type) <u>SAMUEL DESSOFF</u>				DATE SIGNED <u>2/19/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/21/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Nathl Cap Mchm Cem</u>		22d. LOCATION (City, town, or county) <u>Cap Hill</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Jones</u> ADDRESS <u>4217-9th St NW</u>				24a. REC'D BY REGISTRAR <u>2/21/57</u>		24b. REGISTRAR'S SIGNATURE <u>J. M. Dodd</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

118 25 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1943

CERTIFICATE OF DEATH

01939

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>SOUTH DAKOTA</u> b. COUNTY <u>MINER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HOWARD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>- - - - -</u>	
3. NAME OF DECEASED (Type or print) First <u>OSCAR</u> Middle <u>John</u> Last <u>Boos</u>		4. DATE OF DEATH Month <u>2</u> - Day <u>8</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-8-84</u>
9. AGE (In years last birthday) <u>72</u> yrs		10. IF UNDER 1 YEAR: Months <u>9</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BANKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>	
11. BIRTHPLACE (State or foreign country) <u>IOWA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>VALENTINE Boos</u>		14. MOTHER'S MAIDEN NAME <u>CHRISTINA? Boos</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>Unknown</u>	
17. INFORMANT <u>Jessie (wife) Howard</u>		Address <u>South Dakota</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>BRONCHITIS PNEUMONIA, Terminal</u> DUE TO (b) <u>Cerebral Thrombosis, R. M.D. Cerebral Artery</u> DUE TO (c) <u>Cerebral Arteriosclerosis</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>48 hrs</u> <u>5 YRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>DEC. 24, 1956</u> to <u>FEB. 8, 1957</u> , that I last saw the deceased alive on <u>FEB. 8, 1957</u> , and that death occurred at <u>1:30</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert G. Angle</u> M.D.		ADDRESS (Street, city or town, state) <u>5009 Del Ray Avenue, Bethesda, Md.</u>	
DATE SIGNED <u>February 8, 1957</u>			
PHYSICIAN'S NAME (Type) <u>Robert G. Angle, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial-transit</u>	<u>2/9/1957</u>	<u>Wyuka (via Howard, S. Dak.)</u>	<u>Lancaster Co. Nebraska</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>2-8-57</u>	
		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 13 1957

RECEIVED

01940

1913

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				e. STREET ADDRESS <u>7626 Normandy Road</u>			
3. NAME OF DECEASED (Type or print) <u>Charles William Lee Bower</u>				4. DATE OF DEATH <u>February 27 1957</u>			
5. SEX <u>Boy</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 25, 1957</u>	
9. AGE (In years last birthday) yrs. <u>2</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Randolph Bower</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor Alice Belland</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mother - Eleanor Bower - Palmer Park, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemolytic disease of newborn.</u> <u>770.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity.</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Feb. 25</u> , 1957, to <u>Feb. 27</u> , 1957, that I last saw the deceased alive on <u>Feb. 27 - 57</u> , 19, and that death occurred at <u>6:52 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ruth Slantford</u>				ADDRESS (Street, city or town, state) <u>M.D. Wash. San. & Hosp. Takoma Park, Md.</u>			
PHYSICIAN'S NAME (Type) <u>—</u>				DATE SIGNED <u>2-27-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAR. 1/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>WHEATON, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin W. Hyson - Co.</u>				ADDRESS <u>1300-N St. NW - Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>—</u>	
24b. REGISTRAR'S SIGNATURE <u>J. Thompson</u>				DATE <u>FEB 28 1957</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 10 1901

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01941

Reg. Dist. No.

216

1944

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center</u> <u>National Institutes of Health, Bethesda, Md.</u>			d. STREET ADDRESS <u>2113 Van Buren Street</u>		
3. NAME OF DECEASED (Type or print) First <u>Hanford</u> Middle <u>Poole</u> Last <u>Boyer</u>			4. DATE OF DEATH Month <u>February</u> Day <u>14</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3 April 1905</u>		9. AGE (In years last birthday) <u>51</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dispatcher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Ernest Boyer</u>			14. MOTHER'S MAIDEN NAME <u>Ida Poole</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Medical Record, Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>204.1</u> DUE TO <u>PH. M. 1957 EDEMA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>5 DAYS</u> DUE TO (c) <u>5 DAYS</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. m.</u> Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>February 8, 1957</u> to <u>February 14, 1957</u> , that I last saw the deceased alive on <u>February 14, 1957</u> , and that death occurred at <u>6:00 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>2/14/57</u> ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>The Clinical Center</u> PHYSICIAN'S NAME (Type) <u>Garston Goldin, M. D.</u> <u>National Institutes of Health</u> <u>Bethesda 14, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>2/18/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Philadelphia, Pennsylvania</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H.Hines Co. Washington, D. C.</u>		24a. REC'D BY REGISTRAR <u>DATE 12 1957</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

RECEIVED

1957

LIBRARY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1914

CERTIFICATE OF DEATH

01942

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
c. LENGTH OF STAY IN 1b <u>8 days</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MRS. Lillie Flynn Boyston</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>27</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 20, 1879</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife - Own home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles D. Flynn</u>		14. MOTHER'S MAIDEN NAME <u>Julia A. Boyd</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Washington Sanitarium Hospital Records</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 19, 1957</u> , to <u>Feb 27, 1957</u> , that I last saw the deceased alive on <u>Feb 27, 1957</u> , and that death occurred at <u>1:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Boris Rabkin</u>		DATE SIGNED <u>2/27/57</u>	
PHYSICIAN'S NAME (Type) <u>BOBIS RABKIN</u>		ADDRESS (Street, city or town, state) <u>8102 University Lane Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>	22b. DATE THEREOF <u>3/1/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Mausoleum</u>	22d. LOCATION (City, town, or county) (State) <u>Prince George County, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Ramsey</u>		24. REC'D BY REGISTRAR <u>John A. Ladd</u>	
ADDRESS <u>SILVER SPRING 8434 64 AVE MD</u>		DATE <u>3/1/57</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

2000

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1945
CERTIFICATE OF DEATH

01943

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTE ON) <u>Brooke Grove Chronic Hosp.</u>		d. STREET ADDRESS <u>1420 Hongfellow St. N.W.</u>	
3 NAME OF DECEASED (Type or print) <u>Rosa</u> First <u>Lu Bronaugh</u> Middle <u>Lu</u> Last		4. DATE OF DEATH <u>Feb 12 1957</u> Month <u>Feb</u> Day <u>12</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 28, 1968</u> 9. AGE (In years last birthday) <u>88</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk in Navy Dept. Washington</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>in Navy</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John C. Bronaugh</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Callihan Taylor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>For Commission records</u>	
17. INFORMATION <u>given by pt.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> DUE TO <u>Parasitosis</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>yes.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic cystitis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>9.1</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 28, 1957</u> , to <u>Feb 12, 1957</u> , that I last saw the deceased alive on <u>Feb 11, 1957</u> , and that death occurred at <u>215 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Sandy Spring, Md</u> DATE SIGNED <u>2/12/57</u>			
ACTUAL SIGNATURE <u>C. H. Hines</u> M.D.		PHYSICIAN'S NAME (Type) <u>C. H. Hines</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/14/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> ADDRESS <u>Washington, D.C.</u>		24a. REC'D BY REGISTRAR <u>2/14/57</u>	24b. REGISTRAR'S SIGNATURE <u>Gertrude B. Sawler</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1946

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 14, Maryland</u>				c. LENGTH OF STAY IN 1b <u>43 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Berkley</u> Last <u>Butler</u>				4. DATE OF DEATH Month <u>February</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 4, 1897</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Doctor of Medicine</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>William I. Butler</u>			
14. MOTHER'S MAIDEN NAME <u>Eliza Sanks</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right lobe pneumonia</u> DUE TO (b) <u>Moderate arteriosclerosis</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>January 9, 1957</u> to <u>February 21, 1957</u> , that I last saw the deceased alive on <u>February 21, 1957</u> , and that death occurred at <u> </u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Wm. Headley</u> M.D.				The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) <u>William Headley, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 25, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u>				ADDRESS <u>802 Madison Avenue</u>			
24a. REC'D BY REGISTRAR <u>Bessie Thompson</u>				24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEB 26 1957

BUREAU V. 4

FEB 2 1957

RECEIVED

01945

1947

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10019 GEORGIA AVE				d. STREET ADDRESS 10019 GEORGIA AVENUE			
3. NAME OF DECEASED (Type or print) ALIAS ATHANASIOS D CALOMIRIS Middle D CALOMIRIS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX M		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-15-1893	
9. AGE (In years last birthday) 63 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROCTOR		10b. KIND OF BUSINESS OR INDUSTRY SELF		11. BIRTHPLACE (State or foreign country) GREECE	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME DEMITRIOS CALOMIRIS		14. MOTHER'S MAIDEN NAME ELANI		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT James T Calomiris		Address 3504 Jeffery St Sil Spg Md.		INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIO VASCULAR HEART DISEASE DUE TO (c) 2 YRS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 2/11 , 19 55 , to 2/26 , 19 57 that I last saw the deceased alive on 2/15 , 19 57 , and that death occurred at 945 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10011 Georgia Ave DATE SIGNED 2/26/57 ACTUAL SIGNATURE Henry W. Stout MD PHYSICIAN'S NAME (Type) HENRY W. STOUT MD Silver Spring, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		3-1-1957		Glennwood Cemetery		Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO.				ADDRESS 1400 Chapin St. Wash., D.C.		24a. READ BY REGISTRAR FRANK PATTEN	
24b. REGISTRAR'S SIGNATURE				DATE FEB 28 1957			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5 A 000000

REMOVED

1948 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Derwood				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Derwood X 2			
3. NAME OF DECEASED (Type or print) LULA CATHERINE CARTER				4. DATE OF DEATH Feb. 6, 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/3/1872	
9. AGE (In years last birthday) 84 yrs		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James M. Selby				14. MOTHER'S MAIDEN NAME Catherine Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Ruby Beane- Item # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO (b) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 30-40 yrs.						INTERVAL BETWEEN ONSET AND DEATH 20-30 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 1-21, 1957 , to 2-6, 1957 , that I last saw the deceased alive on 1-21, 1957 , and that death occurred at 2 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. G. Hall				ADDRESS (Street, city or town, state) 615 W. Montgomery Ave. Rockville, Md.			
PHYSICIAN'S NAME (Type) W. G. Hall				DATE SIGNED 2-6-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/9/57		22c. NAME OF CEMETERY OR CREMATORY Forest Oak		22d. LOCATION (City, town, or county) (State) Gaithersburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR 2/11/57		24b. REGISTRAR'S SIGNATURE Laurell Kragtorp	

MEDICAL CERTIFICATION

HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 18 1957

RECEIVED

1949 CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a STATE Maryland b COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b 3 WEEKS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mont. Co. Gen. Hospital, Olney, Md.				d STREET ADDRESS Rural Rockville, Md.			
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3 NAME OF DECEASED (Type or print) Wallace First Cashell Middle Cashell Last				4. DATE OF DEATH Month Feb. Day 10, Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 3, 1877		9. AGE (In years last birthday) yrs 79	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George C. Cashell				14. MOTHER'S MAIDEN NAME Anne Elizabeth Barnsley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hilda Cashell Address Rural Rockville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.1 DUE TO Gangrene Left Foot Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Isen. art. Schenist cardiac DUE TO Failure (c) Failure						INTERVAL BETWEEN ONSET AND DEATH 3 weeks 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 8 May, 1955 to 10 Feb., 1957 that I last saw the deceased alive on 10 Feb., 1957 , and that death occurred at 7 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE John Basil Ziegler M.D.				ADDRESS (Street, city or town, state) OLNEY MD			
PHYSICIAN'S NAME (Type) JOHN B. ZIEGLER				DATE SIGNED 11 Feb 57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 12, 1957		22c. NAME OF CEMETERY OR CREMATORY St. John's		22d. LOCATION (City, town, or county) (State) Olney, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Smith				ADDRESS Laytonsville		24a. REC'D BY REGISTRAR DATE 2/12/57	
				24b. REGISTRAR'S SIGNATURE Robert B. Lawler			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

FEB 20 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01948

1950

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MASSACHUSETTS b. COUNTY BARNSTABLE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			c. LENGTH OF STAY IN 1b Dec. 8, 1956	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FALMOUTH			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 616 WOODSIDE PARKWAY				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELIZA Middle BLOSSOM Last CHASE				4. DATE OF DEATH Month FEBRUARY Day 17 Year 19 57			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 9, 1884		9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) MASSACHUSETTS		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ALFRED BROWNELL			14. MOTHER'S MAIDEN NAME SARA JONES				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. ---		17. INFORMANT Address MRS. LOUIS J. DOYLE, 616 WOODSIDE PARKWAY, SS., MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) --- DUE TO (c) ---							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) FRANK J. BROSCART				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
TRANS. & BURIAL		2/21/57		MELROSE CEMETERY		BROCKTON, MASS.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. E. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 2/20/57	
				24b. REGISTRAR'S SIGNATURE Francis Potter			

RECEIVED

FEB 25 1957

BUREAU V. S.

1

INSTRUCTIONS

PENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

1951

01949

Reg. Dist. No. 214

1. PLACE OF DEATH Montgomery Co.				2. USUAL RESIDENCE (HOME) OF DECEASED 6812 Piney Branch Rd. Wash. 12, D. C.			
CITY (If outside corporate limits, write RURAL (7 Mo & LENGTH OF STAY (in this place) 57 OR and give nearest town) TOWN Si. Spg. (7 days 7-1566-2-24-57				CITY (If outside corporate limits, write RURAL and give nearest town) OR WASHINGTON			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Cedarcroft San. & Hosp. R.F.D.#2, Col. Rd.				STREET ADDRESS (If rural give location) 6812 Piney Branch 47X-5			
3. NAME OF DECEASED (Type or Print) George W Chas e				4. DATE OF DEATH (Month) (Day) (Year) Feb. 24 19 57			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widower	8. DATE OF BIRTH Mar. 31, 1872	9. AGE last birthday 84 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Builder, Taxi Dr.			10b. KIND OF BUSINESS OR INDUSTRY Builder Taxi Dr.		11. BIRTHPLACE (State or foreign country) Brattleboro, Vermont		12. CITIZEN OF WHAT COUNTRY? America
13. FATHER'S NAME Not Available				14. MOTHER'S MAIDEN NAME Not Available			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS Hospital Records			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						16. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) Antecedent Cause(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)						INTERVAL BETWEEN ONSET AND DEATH 24 hours 10 months 24 hours	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDIT ON CAUSING DEATH Chronic Brain Syndrome, Cerebral Arteriosclerosis						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 17, 19 57, to Feb 24, 19 57, that I last saw the deceased alive on Feb. 24, 19 57, and that death occurred at 4:45 P.M. from the causes and on the date stated above.							
SIGNATURE Henry E. Andrie				ADDRESS (Street, city, town, state) 7600 Carroll Ave. Takoma Park, Md.		DATE SIGNED 2/24/57	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb. 27, 1957		NAME OF CEMETERY OR CREMATORY George Washington Cemetery		LOCATION (City, town, or county) (State) Hyattsville, Md.	
24. REC'D BY REGISTRAR FEE 27 1957		REGISTRAR'S SIGNATURE Frances Potter		25. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters		ADDRESS 254 Carroll St NW DC	

RECEIVED

FEB 27 1957

BUREAU V. 1

1952

CERTIFICATE OF DEATH

01950

Reg. Dist. No.

218

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALT.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GAITHERSBURG</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Md.</u>			
c. LENGTH OF STAY IN 1b <u>3yrs + 5mo.</u>				d. STREET ADDRESS <u>2110 St. Paul St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Asbury Methodist Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Elizabeth</u> First <u>Agnes</u> Middle <u>Childs</u> Last				4. DATE OF DEATH <u>FEB 28 1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 28, 1866</u>	
9. AGE (In years last birthday) <u>90</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>MD.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John P. Childs</u>				14. MOTHER'S MAIDEN NAME <u>MARY BRAYSHAW</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Asbury Methodist Home Siles - Gaithersburg</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE HEART FAILURE</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>FRACTURE OF RT. hip & hepatois</u> (c) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>							INTERVAL BETWEEN ONSET AND DEATH <u>not</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>47</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury or accident for Part II of item 18.) <u>Fell in Room 2-3-57 MEDICAL EXAMINER</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>7-17</u> , 19 <u>56</u> , to <u>FEB 28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>FEB 27</u> , 19 <u>57</u> , and that death occurred at <u>12:10 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Donald E. Hlaw</u>				M.D. <u>4208 ANTHONY ST. KENSINGTON 2083</u>			
PHYSICIAN'S NAME (Type)				DATE SIGNED <u>md 37</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/2/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Dickens & Sons</u>				ADDRESS <u>Balto. 17th</u>		24a. REC'D BY REGISTRAR DATE <u>3/1/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Alfreda G. Coker</u>			

BUREAU V. S.

MAR 4 1957

RECEIVED

1953

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. LENGTH OF STAY IN 1b Kensington Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Rest Home				d. STREET ADDRESS 8301-16th. St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) HELEN L. CLARK				4. DATE OF DEATH Februaury 7, 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 30, 1879	
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR 2 Months 7 Days		11. IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Edwin Leech				14. MOTHER'S MAIDEN NAME Celia H. Kent			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Merton English-Cherry Chase, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 465X Pulmonary Infarction, right lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hyper-trophic Arthritis, Knees DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 3 days 6 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 1953 to Feb 7, 1957 , that I last saw the deceased alive on Feb 6, 1957 , and that death occurred at 1:55 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John Lawrence Avery M.D.				ADDRESS (Street, city or town, state) 10110 Georgia Ave Silver Spring, Md.			
DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/9/57		22c. NAME OF CEMETERY OR CREMATORY Glenwood		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 2-8-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
FEB 13 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01952

1954

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) 9421 Rockville Pike		d. STREET ADDRESS 9421 Rockville Pike	
3. NAME OF DECEASED (Type or print) First Georgia Middle M. Last CLIFFORD		4. DATE OF DEATH Month February Day 8 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 27, 1880
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR: Months 5 Days 11 IF UNDER 24 HRS: Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Otterville, Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William D. McAdams		14. MOTHER'S MAIDEN NAME Annie Curtis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Clark M. Clifford-Son-Same Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PS (c) 		INTERVAL BETWEEN ONSET AND DEATH 24 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Plasma cell adenocarcinoma		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1956 to Sept 1957 , that I last saw the deceased alive on Sept 8, 1957 , and that death occurred at 3:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3710 Leland Street, Chevy Chase, Md. DATE SIGNED Bessie M. Thompson			
ACTUAL SIGNATURE J. Lawn Thompson M.D.		PHYSICIAN'S NAME (Type) J. Lawn Thompson, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit		22b. DATE THEREOF 2/8/1957	
22c. NAME OF CEMETERY OR CREMATORY St. Patrick's		22d. LOCATION (City, town, or county) (State) Madison County Illinois	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.		24a. REC'D BY REGISTRAR 2-8-57	
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

BUREAU V. S.

FEB 11 1901

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate should be retained for use as a burial transit permit.

VS 1-5C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01953

CERTIFICATE OF DEATH

1955

Reg. Dist. No. 216

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Bethesda</u>		<u>5 yrs.</u>		TOWN <u>Bethesda</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5146 Newport Ave. Wash. DC</u>				STREET ADDRESS (If rural give location) <u>5146 Newport Ave. Wash. 16DC</u>			
3. NAME OF DECEASED (Type or Print) <u>Florence M. Collier</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 17 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>9/6/82</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>11</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Pathrick McKelvey</u>				14. MOTHER'S MAIDEN NAME <u>-Floer Mary A. Hearn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Florence Hanback, 5146 Newport Ave.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Carcinoma of rectum with</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 years</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>generalized abdominal metastases</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u></u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u></u>							
19a. DATE OF OPERATION <u>Nov 4, 1955</u>		19b. MAJOR FINDINGS OF OPERATION <u>see (A) above</u>		20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u></u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u></u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u></u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u></u>			
22. I hereby certify that I attended the deceased from <u>March 1955</u> to <u>Feb 1957</u> , that I last saw the deceased alive on <u>2-17-57</u> , and that death occurred at <u>7:50 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>C. P. Ryland</u> M.D.				ADDRESS (Street, city, town, state) <u>4400 - 49 ST NW</u>		DATE SIGNED <u>2-17-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/20/57</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		LOCATION (City, town, or county) (State) <u>Suitland, Prince Geo. Md.</u>	
24. REC'D BY REGISTRAR <u>Beau M. Thompson</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>7557 Wisc. Ave. Bet</u>	
DATE <u>2-20-57</u>							

RECEIVED

FEB 21 1957

RECEIVED

1915

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>D.C. Union</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>D.C.</i> b. COUNTY <i>Montgomery</i>	
c. LENGTH OF STAY IN 1b		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San. + Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Maria Daniel Costello</i>		4. DATE OF DEATH Month Day Year <i>Feb. 8 1957</i>		5. SEX <i>Female</i>	
6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>12-4-91</i>	
9. AGE (In years last birthday) <i>65 yrs.</i>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Mexico</i>		12. CITIZEN OF WHAT COUNTRY? <i>America</i>		13. FATHER'S NAME <i>Daniel</i>	
14. MOTHER'S MAIDEN NAME <i>?</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>Chart</i>	
17. INFORMANT <i>Chart</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary edema</i> DUE TO (b) <i>Cerebral hemorrhage, left frontal lobe</i> DUE TO (c) <i>Intracerebral rupture of military aneurysm, ant. cerebral artery</i>		INTERVAL BETWEEN ONSET AND DEATH <i>less than 1 day</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>			
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Chas H W. Lickon</i>		M.D.		DATE SIGNED <i>2/8/57</i>	
PHYSICIAN'S NAME (Type) <i>Chas H W. Lickon</i>		ADDRESS (Street, city or town, state) <i>7401 Blair Rd. NW Wash DC</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/14/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Mt Olivet Am</i>	
22d. LOCATION (City, town, or county) (State) <i>Wash D.C.</i>		23. FUNERAL DIRECTOR'S SIGNATURE <i>W R Hupstmann</i>		24a. REC'D BY REGISTRAR <i>2/12/57</i>	
24b. REGISTRAR'S SIGNATURE <i>W R Hupstmann</i>		24c. ADDRESS <i>5732 Georgia ave</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

S. A. 1911

1911

1911

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01955

Reg. Dist. No. 215

1956

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE North Carolina b. COUNTY	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 13 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Maryland		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newton	
3. NAME OF DECEASED (Type or print) First CARLOS Middle DANIEL Last CROWE		4. DATE OF DEATH Month February Day 11 Year 1957	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 June 1926
9. AGE (In years last birthday) 30 yrs.		10. IF UNDER 1 YEAR Months 11 Days 11 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Edison Crowe		14. MOTHER'S MAIDEN NAME Cally Jane Sigmund	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 8-31-43 to 2-1-57 (Unknown)	
17. INFORMANT Official Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Melanoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 190x (c) 190x			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 190x			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour ? a. m. 4-6- p. m. 19 56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) USNAS Beesville, Tex.		20f. (City or town) (County) (State) Texas	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/> .			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart, MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-15-57	
22c. NAME OF CEMETERY OR CREMATORY Private Cemetery		22d. LOCATION (City, town, or county) (State) Conover, North Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md		24a. REC'D BY REGISTRAR 11 Feb. 57	
		24b. REGISTRAR'S SIGNATURE <i>May S. Parrelly</i>	

MEDICAL CERTIFICATION

2

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

U.S. AIR FORCE

1957

100

1957

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 6 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5216 Edgemore Lane				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Kathleen First C Middle CROWLEY Last				4. DATE OF DEATH February 24, 19 57 Month Day Year			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 12, 1875		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 6 Days 12 Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Chicago, Ill.		12. CITIZEN OF WHAT COUNTRY? US A.	
13. FATHER'S NAME William Casey				14. MOTHER'S MAIDEN NAME Mary Casey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Clarence Enzler-Item # 2 Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerosis (b) Arteriosclerosis DUE TO (c) Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 1 HR Admission YRS (OLD AGE)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bad fall at Home Sep 17 at - struck her head							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Fell out of bed & struck her head				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour 11 a. m. 2 17 1957 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME	
20f. (City or town) Suitland, Pr. Geo.				20g. (State) Md.			
21. I certify that I attended the deceased from 9/17 , 19 57 , to 2/24 , 19 57 , that I last saw the deceased alive on 2/23 , 19 57 , and that death occurred at 9 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Leo I. Donovan M.D.				ADDRESS (Street, city or town, state) 8016 Georgetown Rd., Bethesda, Md.			
DATE SIGNED 2/25/57							
PHYSICIAN'S NAME (Type) Leo I. Donovan-8016 Old Georgetown Rd., Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/27/57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Pr. Geo. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE 2-26-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. S.

FEB

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1958

CERTIFICATE OF DEATH

01957

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Redland c. LENGTH OF STAY IN 1b 23 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Redland d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Angeline None Cullers		4. DATE OF DEATH Month Day Year Feb. 25 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 11, 1872
9. AGE (In years last birthday) 84 yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY West Virginia	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Snyder		14. MOTHER'S MAIDEN NAME Unk rwn Halterman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. No	
17. INFORMANT Mrs. Catherine V. Fraley, Redland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure, 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO (c) Hypertension Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC PYELITIS.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January, 1956, to Feb 25, 1957, that I last saw the deceased alive on Feb 25, 1957, and that death occurred at 1 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Luciano R. Leal M.D. 108 N. Frederick Ave. ACTUAL SIGNATURE Luciano R. Leal M.D. Gaithersburg Md. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/28/57	
22c. NAME OF CEMETERY OR CREMATORY Cullers Run		22d. LOCATION (City, town, or county) (State) Mathias, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond Barber, Saytonville Md ADDRESS		24a. REC'D BY REGISTRAR DATE 3-1-57 24b. REGISTRAR'S SIGNATURE Abraham L. Croke	

RECEIVED

MAR 4 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1959

CERTIFICATE OF DEATH

Reg. Dist. No.

01958

216

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 7 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5811 Walton Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charlotte Middle C. Last DALY				4. DATE OF DEATH Month February Day 27 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 12,	
9. AGE (In years last birthday) 86 yrs		10. IF UNDER 1 YEAR Months 2 Days 15 Hours Min. 		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY - - - - -			
13. FATHER'S NAME Charles Cotton				14. MOTHER'S MAIDEN NAME Ella Stewart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Robert T. Daly-Same Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Broncho pneumonia 471X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Washington				20g. (County) D. C.		20h. (State) D. C.	
21. I certify that I attended the deceased from Feb. 24, 1957 , to Feb. 27, 1957 , that I last saw the deceased alive on Feb. 24, 1957 , and that death occurred at 7:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1635 Irving St. N. W., Wash. D. C. DATE SIGNED 2/27/57 ACTUAL SIGNATURE A. J. Connally M.D. 1635 Irving St. N. W., Wash. D. C. PHYSICIAN'S NAME (Type) A. J. Connally, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/2/57		22c. NAME OF CEMETERY OR CREMATORY Rock Creek		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md				24a. REC'D BY REGISTRAR 2-27-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

RECEIVED

MAR 1 1957

BUREAU V. T.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1960

CERTIFICATE OF DEATH

01959

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shelton Green</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shelton Green</u> d. STREET ADDRESS <u>19907 Marlham</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Richard Walter Dameron</u>				4. DATE OF DEATH Month Day Year <u>Feb 17 1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 15, 1897</u> 39 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Taxi Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard C Dameron</u>				14. MOTHER'S MAIDEN NAME <u>Cleopatra M. Jackson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Francis Dameron</u> Address <u>9907 Marlham St Sping</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Chronic C-V Disease</u> DUE TO <u>with Myocardial Damage</u> (c) <u>5 years</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1945</u> to <u>2/17</u> , 1957, that I last saw the deceased alive on <u>2/16</u> , 1957, and that death occurred at <u>6:05 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frederick Y. Donn</u> M.D.				ADDRESS (Street, city or town, state) <u>1801 K St., N.W.</u>			
PHYSICIAN'S NAME (Type) <u>Frederick Y. Donn</u>				DATE SIGNED <u>Wash D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>2-20-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Baptist Church</u>		22d. LOCATION (City, town, or county) (State) <u>Ullage Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Neal Funeral Home</u> ADDRESS <u>4812 Adams St</u>				24a. REC'D BY REGISTRAR <u>James Potter</u> DATE <u>25 1957</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL ■■■ ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 25 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
1916 CERTIFICATE OF DEATH									
Reg. Dist. No. 01960 223									
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b 4 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 517 Albany Avenue					d. STREET ADDRESS 6919 Clarendon Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jehanna First Middle Last					4. DATE OF DEATH February 17 19 57 Month Day Year				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 16, 1861		9. AGE (In years last birthday) 95 yn	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Iowa			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Joachim Doehl					14. MOTHER'S MAIDEN NAME Sophia Walters				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Hilda D. Cornell-Same Item #2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Virus Pneumonia DUE TO Infection Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Old age (c) Old age								INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old age								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/11 , 19 57 , to 2/17 , 19 57 , that I last saw the deceased alive on 2/17 , 19 57 , and that death occurred at 10:30 PM , from the causes and on the date stated above.									
ACTUAL SIGNATURE Chas. H. McLaughlin M.D.					ADDRESS (Street, city or town, state) DATE SIGNED				
PHYSICIAN'S NAME (Type) Chas. H. McLaughlin, 500 Underwood St NW Wash DC									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit		22b. DATE THEREOF 2/18/1957		22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery			22d. LOCATION (City, town, or county) (State) Clinton Co. Iowa		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave., Bethesda, Md					24a. REC'D BY REGISTRAR DATE 2/20/57		24b. REGISTRAR'S SIGNATURE		

RECEIVED

FEB 24 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01961
Reg. Dist. No. 2

1917

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery Co.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park 8 mo.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park 11</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sanitarium and Hospital</i>		d. STREET ADDRESS <i>22 Seminary Drive</i>	
3. NAME OF DECEASED (Type or print) First <i>Aubrey</i> Middle <i>Vance</i> Last <i>Dick</i>		4. DATE OF DEATH Month <i>Feb</i> Day <i>21</i> Year <i>1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>Cauc</i>	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>2/18/1941</i>
	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <i>16 yrs</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Student</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Colorado</i>		12. CITIZEN OF WHAT COUNTRY? <i>America</i>	
13. FATHER'S NAME <i>Avery Dick</i>		14. MOTHER'S MAIDEN NAME <i>Arlene McToggart</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Washington Sanitarium and Hospital Records</i>		Address <i>Takoma Park, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>drowning</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>429.4</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Injured while swimming in pool - Wash. Missions College</i>	
20c. TIME OF INJURY Month, Day, Year <i>2-21-1957</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Swimming Pool</i>	20f. (City or town) <i>Takoma Park</i> (County) <i>Montgomery</i> (State) <i>Md.</i>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Frank J. Broschant</i>		DATE SIGNED <i>2-22-57</i>	
EXAMINER'S NAME (Type) <i>FRANK J. Broschant</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>FEB. 25, 1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>GEORGE WASHINGTON CEM.</i>	22d. LOCATION (City, town, or county) <i>ROCKVILLE, MD.</i> (State) <i>MD.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter 254 Carroll St. NW</i>		24a. RECORD BY REGISTRAR <i>2-25-57</i> 24b. REGISTRAR'S SIGNATURE <i>William J. Scott</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

FEB 27 1957

BUREAU V. S.

1928

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN lb 3 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Randolph Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPHINE MOSELLE JARBOE DICKERSON		4. DATE OF DEATH Feb. 20, 1957	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 5, 1875
9. AGE (In years last birthday) 81		10. IF UNDER 1 YEAR 3 Months 15 Days 19 Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Eugene E. Jarboe		14. MOTHER'S MAIDEN NAME Mary Eleanor Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO none	
17. INFORMANT Dr. Eugene Jarboe, 5211 Conn. Ave. N. W.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Cessation due to DUE TO 4:00 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis DUE TO Gen. Arteriosclerosis (c) Constrictive Heart Failure		INTERVAL BETWEEN ONSET AND DEATH 5 min 5-10 yrs Indef	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/1/57 to 2/20/57 , that I last saw the deceased alive on 2/20/57 , and that death occurred at 6:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stephen N. Jones M.D.		ADDRESS (Street, city or town, state) Rockville Md DATE SIGNED 2/20/57	
PHYSICIAN'S NAME (Type) Stephen N. Jones		Rockville Md 2/20/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/23/57	22c. NAME OF CEMETERY OR CREMATORY Monocacy Cemetery	22d. LOCATION (City, town, or county) (State) Beallsville Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		ADDRESS 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE 2/21/57 Dwight Kuytorp	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 25 1957

BUREAU V. S.

1961 CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 2 hrs. 4 min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital				d. STREET ADDRESS Rt. #2			
3. NAME OF DECEASED (Type or print) First Middle Last Dill				4. DATE OF DEATH Month Day Year February 26 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/26/57		9. AGE (In years last birthday) yrs. Months Days Hours Min. 2 6		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn
10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Joshua Leonard Dill				14. MOTHER'S MAIDEN NAME Charlotte Estella Kaiser			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Mother Same as 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X Prematurity - 5 1/2 mos gestation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cause of premature labor not clear, DUE TO (c) no toxemia, Rh positive mother.							INTERVAL BETWEEN ONSET AND DEATH Due date June 12/57
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from Feb 26 , 19 57 , to Feb 26 , 19 57 , that I last saw the deceased alive on Feb 26 , 19 57 , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED W. A. Linthicum M.D. Gaithersburg, Md. 2/26/57							
ACTUAL SIGNATURE W. A. Linthicum				PHYSICIAN'S NAME (Type) W. A. Linthicum, M. D. Gaithersburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Buried		Feb 28 1957		Providence		Hagerstown Md	
23. FUNERAL DIRECTOR'S SIGNATURE Robert W. Barber				ADDRESS Providence		24a. REC'D BY REGISTRAR DATE 2/28/57	
						24b. REGISTRAR'S SIGNATURE Robert B. Lawler	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or in any event within 72 hours after death.

BUREAU V. S.

27 1937

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1962 CERTIFICATE OF DEATH

01964

Reg. Dist. No. 266

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 478</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>3824 Segation ST. N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>LETA</u> First Middle Last		4. DATE OF DEATH Month <u>2</u> Day <u>11</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-14-81</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>10</u> Days <u>27</u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wisconsin</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jacob Wobee</u>		14. MOTHER'S MAIDEN NAME <u>Lena Jahnke</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>Sullivan Scott (daughter)</u>		Address <u>Wash., D.C. 3824 Segation ST. N.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency</u> DUE TO <u>Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes Mellitus</u> DUE TO (c) <u>Caloric Rheumatic Mitral Valvulitis</u>		INTERVAL BETWEEN DEATH AND EXAMINATION <u>3 days</u> <u>3+ yrs.</u> <u>3+ yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Caloric Rheumatic Mitral Valvulitis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input checked="" type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9 Feb 1957</u> to <u>11 Feb 1957</u> , that I last saw the deceased alive on <u>10 Feb 57</u> , and that death occurred at <u>5:00 P.M.</u> , from the causes and on the date stated above.			
ATTEST: <u>A.H. Richwine</u> M.D.		ADDRESS (Street, city or town, state) <u>5522 Eastern Ave N.E. Wash. D.C.</u>	
SIGNATURE (Type) <u>A.H. RICHWINE</u>		DATE SIGNED <u>Feb 15, 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/14/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>7557 Wise Ave. Beth</u>	
24a. REC'D BY REGISTRAR <u>2-15-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

RECEIVED
FEB 18 1957
DEAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1963

CERTIFICATE OF DEATH

01965 74

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8623 PINEY BRANCH RD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FRANCES JUSTINE DOVE		4. DATE OF DEATH Month Day Year FEB. 19 1957	
5. SEX FE	6. COLOR OR RACE WH-	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 7, 1905
9. AGE (In years last birthday) yrs 51		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Refrigerator and audit clerk Raleigh's		10b. KIND OF BUSINESS OR INDUSTRY IOWA	
11. BIRTHPLACE (State or foreign country) IOWA		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME BERNARD ALBRECHT		MOTHER'S MAIDEN NAME SOPHIE NIEMANN	
14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		15. SOCIAL SECURITY NO. 577-05-5409	
16. INFORMANT MRS MARIE CHALEY		Address 8623 PINEY BR RD (listed)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma thyroid gland with metastases 194X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. 194X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatic-hypertensive heart disease - 5 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from NOV 29, 1957 to Feb 19, 1957 , that I last saw the deceased alive on Feb 19, 1957 , and that death occurred at 3 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William F. Simpson		M.D. 6246 N.H. Ave N.E.	
PHYSICIAN'S NAME (Type) WILLIAM F. SIMPSON		DATE SIGNED FEB 19, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 2/25/57	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co.		24. REC'D BY REGISTRAR Feb 20 1957	
ADDRESS Washington, D. C.		24b. REGISTRAR'S SIGNATURE Frances Patter...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
FEB 25 1957
BUREAU Y. K.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO VITAL REGISTRAR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1964

CERTIFICATE OF DEATH

01966

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE District of Columbia b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 52 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center				d. STREET ADDRESS 1228 Eye St., N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Phalia Vida Eason				4. DATE OF DEATH Month Day Year February 28th, 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 21st, 1894		9. AGE (in years last birthday) yrs 62	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Government employee		10b. KIND OF BUSINESS OR INDUSTRY U. S. Government		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert W. Eason				14. MOTHER'S MAIDEN NAME Emma Meyers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Not available		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF BREAST, METASTASES TO LIVER + BONE DUE TO LIVER + BONE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE						INTERVAL BETWEEN ONSET AND DEATH 2 years	
						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 7, 19 57 to February 28, 19 57 , that I last saw the deceased alive on February 28, 19 57 , and that death occurred at 3:21P M, from the causes and on the date stated above							
ACTUAL SIGNATURE Norman G. Levinsky M.D.				ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 3/1/57	
PHYSICIAN'S NAME (Type) Norman G. Levinsky, M. D.				The National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 3/2/57		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Pecatonica, Illinois	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Washington, D. C.				24a. REC'D BY REGISTRAR DATE 24 1957		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

RECEIVED

MAR 4 1957

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01967

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 12 hrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hos p.		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montg. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase d. STREET ADDRESS 3103 Winnett Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Emery Engels First Middle Last 4. DATE OF DEATH Feb. 17, 1957 Month Day Year		5. SEX female 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 2-24-04 9. AGE (In years last birthday) 52 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 13. FATHER'S NAME James Emery		10b. KIND OF BUSINESS OR INDUSTRY Cal. 11. BIRTHPLACE (State or foreign country) Cal. 12. CITIZEN OF WHAT COUNTRY? USA	
14. MOTHER'S MAIDEN NAME Emily Hartrick 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. Hosp. Records 17. INFORMANT Address Hosp. Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage & Contusion DUE TO (b) Fall down stairs at home Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Fall down stairs at home INTERVAL BETWEEN ONSET AND DEATH 12 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Fall down stairs at home		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year 11 Hour XX a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	
20f. (City or town) Chevy Chase (County) Montg. (State) Md.		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .	
ACTUAL SIGNATURE Frank J. Broschart M.D. EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 2/17/57		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 2/20/1957 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem. 22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Sanders ADDRESS 1756 P. ave. N.W.		24a. REC'D BY REGISTRAR DATE 2-20-57 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

RECEIVED

FEB 25 1957

BUREAU V. a

01968

1918

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>305 Baltimore Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>Virginia</u> Last <u>English</u>				4. DATE OF DEATH Month <u>February</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 5 1874</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>13</u>	IF UNDER 24 HRS Hours <u>13</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Trevey</u>				14. MOTHER'S MAIDEN NAME <u>Victoria Harris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Hospital Record</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Bladder</u> <u>181X</u> DUE TO <u>& Metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>Jan 157</u> , to <u>Feb 28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 28</u> , 19 <u>57</u> , and that death occurred at <u>3:40 p.m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Raymond O. Wise</u>		ADDRESS (Street, city or town, state) <u>7600 Carroll Ave., Takoma Park</u> DATE SIGNED <u>Feb 28/57</u>					
PHYSICIAN'S NAME (Type) <u>Raymond O. Wise</u>		7600 Carroll Ave., Takoma Park 2/28/57					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/4/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>	22d. LOCATION (City, town, or county) (State) <u>Gaithersburg, Maryland</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	24a. REC'D BY REGISTRAR <u>3/2/57</u>	24b. REGISTRAR'S SIGNATURE <u>William Dodd</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 5 1972

FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1966

CERTIFICATE OF DEATH

Reg. Dist. No.

01969

214

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norbeck c. LENGTH OF STAY IN 1b 58 Weeks d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bradford Nursing Home		2. USUAL RESIDENCE (Where deceased lived) II Institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville, d. STREET ADDRESS Elizabeth Avenue., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Hattie Middle W. Last Evans		4. DATE DEATH Month Feb. Day 23, Year 19 57	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 11, 1887
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Bethel, N. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Reed Warren		14. MOTHER'S MAIDEN NAME Maria Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Letha E. Payton		Address Elizabeth Ave., Rockville, Md.	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema, Acute DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial failure DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Feb. 2, 1957 to Feb. 23, 1957	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from FEB. 2, 1957 to FEB. 23, 1957 that I last saw the deceased alive on FEB. 21, 1957 , and that death occurred at 10:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Clive E. Jackson, M.P., M.D.		ADDRESS (Street, city or town, state) RD 1, Gaithersburg, Md.	
PHYSICIAN'S NAME (Type) Clive E. Jackson		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 2/25/57	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Greenville, E.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Swondy		ADDRESS Rockville, Md.	
24a. REC'D BY REGISTRAR 2/28/57		REGISTRAR'S SIGNATURE Frances Totten	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 1 1957

REAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01970

1967

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE West Virginia COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellison	
d. NAME OF HOSPITAL (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS (none)	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John Marshall Ferguson		4. DATE OF DEATH February 6, 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 2, 1900
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR: Months 8 Days 4 Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad worker		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J. Ferguson		14. MOTHER'S MAIDEN NAME Ruth A. Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 234-14-4846	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Cancer extending to base of skull			
144X DUE TO pituitary, brain and spinal cord			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Epidermoid Cancer of buccal mucosa			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 11, 1956 , to February 6, 1957 , that I last saw the deceased alive on February 6, 1957 , and that death occurred at 10:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Arthur J. Garceau M.D.		ADDRESS (Street, city or town, state) The Clinical Center	
PHYSICIAN'S NAME (Type) ARTHUR J. GARCEAU, M. D.		DATE SIGNED 2/7/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 2/8/57		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Private family		22d. LOCATION (City, town, or county) (State) Summers Co. W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. P. [illegible]		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE 2-8-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

BUREAU V. S.

FEB 13 1957

RECEIVED

1968 CERTIFICATE OF DEATH

01971

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN Ib 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. General Hospital, Inc.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lula Middle Belle Last Ford		4. DATE OF DEATH Month February Day 7 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/22/65
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Brown		14. MOTHER'S MAIDEN NAME Molly Pottinger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO (c) Heart Decompensation Generalized PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (or) Hypertension			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 1956 to Jan. 7, 1957 , that I last saw the deceased alive on Jan 7, 1957 , and that death occurred at 10:13 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 108 N. Frederick Ave. Gaithersburg Md. DATE SIGNED			
ACTUAL SIGNATURE Luciano I. Leal M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) Luciano I. Leal		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/9/57	
22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner B. Humphrey ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 1-9-57	
24b. REGISTRAR'S SIGNATURE Gertrude B. Lawler			

MEDICAL CERTIFICATION

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01972

1969

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>6403 Connecticut Avenue</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rita Repetti Fowlee</u>				4. DATE OF DEATH Month Day Year <u>2 - 11 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-3-78</u>	
9. AGE (In years last birthday) <u>78</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George Raphael Repetti</u>				14. MOTHER'S MAIDEN NAME <u>Alice Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>				17. INFORMANT Address <u>Judge J. V. Morgan (attorney)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>							
331X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio-sclerosis</u>							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>terminal bronchial pneumonia</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>2/7</u> , 19 <u>57</u> , to <u>2/11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/10</u> , 19 <u>57</u> , and that death occurred at <u>8:45 a.m.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John V. Dolan</u> M.D.				ADDRESS (Street, city or town, state) <u>3100 Conn Ave, Wash DC</u>			
PHYSICIAN'S NAME (Type) <u>John V. Dolan</u>				DATE SIGNED <u>2/11/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/13/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>2-12-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

BUREAU V. S.

1957

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CERTIFICATE OF DEATH

Reg. Dist. No. 216

1970

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Mar Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		d. STREET ADDRESS <u>5304 Augusta Street</u>	
3. NAME OF DECEASED (Type or print) First <u>GRACE</u> Middle <u>EVA</u> Last <u>FRENCH</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>2</u> Year <u>1957</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-28-71</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>4</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (State or foreign country) <u>Ripley, MAINE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Katen, ELMER</u>		14. MOTHER'S MAIDEN NAME <u>Un known</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Leita E. Hamilton (Above)</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>C.V.A.</u> <u>422.1</u> DUE TO <u>Cardiovascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Linear fracture of R. scapula</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <u></u> at work <u></u>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that I attended the deceased from <u>Jan. 18, 1957</u> to <u>Feb. 2, 1957</u> , that I last saw the deceased alive on <u>Feb. 2, 1957</u> , and that death occurred at <u>10:40 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>DR. MARKS (C. Williams)</u> M.D.		ADDRESS (Street, city or town, state) <u>Wisconsin Ave. Bethesda Md. 760 r/17</u>	
PHYSICIAN'S NAME (Type) <u>I. L. Marks, M.D.</u>		DATE SIGNED <u>Feb 5 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-transit</u>		22b. DATE THEREOF <u>2/5/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill</u>
22d. LOCATION (City, town, or county) (State) <u>Penobscot Co. Maine</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Bethesda</u>		24a. REC'D BY REGISTRAR <u>DATE 2-5-57</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 7 1907

RECEIVED

1971

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Dist. of Col.</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Garden Sanit.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Minnie K.</u> Middle <u>—</u> Last <u>FREUND.</u>				4. DATE OF DEATH Month <u>February</u> Day <u>7</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 5-1876</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Month <u>9</u> Days <u>2</u>		IF UNDER 24 HRS Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>IRELAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Richard Karney</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Karney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Julius Freund</u> Address <u>1136-12th ST NW DC</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of Right Femur - Jan. 7, 1957</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Patient fell in her home on Jan. 7, 1957</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>March 1947</u> to <u>Feb. 7, 1957</u> that I last saw the deceased alive on <u>January 6, 1957</u> , and that death occurred at <u>5:25 A.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>James M. Loftus</u> M.D. <u>1673 - Park Road N.W.</u>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>Feb. 9, 1957</u>		<u>MT. OLIVET CEM.</u>		<u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin W. Hyson Co.</u>				ADDRESS <u>1300 - N 1st NE Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>Feb 8 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO LOCAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01975

1972

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	c. LENGTH OF STAY IN 1b <u>15 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase, 15</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>3704 Shepard Street</u>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>Sophie</u> Last <u>Funk</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/15/74</u>
9. AGE (In years last birthday) <u>82</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pennsylvania</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Moyers</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Gongaware</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Mrs. J. Symons -- same</u>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> (c)		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile Parkinsonism, Right Hip Fracture</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p. m. Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Suburban Hosp. Bethesda, Md.</u>
20f. (City or town) <u>Bethesda</u>		(County) (State)
21. I certify that I attended the deceased from <u>11 Feb.</u> , 19 <u>57</u> , to <u>25 Feb.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>24 Feb.</u> , 19 <u>57</u> , and that death occurred at <u>6:20</u> A.M., from the causes and on the date stated above.		
ACTUAL SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>25 Feb.</u>
PHYSICIAN'S NAME (Type) <u>J. E. ASH</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/28/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brush Creek</u>
22d. LOCATION (City, town, or county) <u>Westmoreland Co., Pennsylvania</u>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 2-26-57</u>
24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		

U. S. A.

1957

U. S. A.

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

I TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01976

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY MONTGOMERY		STATE MARYLAND		STATE D.C.		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) CHEVY CHASE		LENGTH OF STAY (in this place) 3 WEEKS		CITY (If outside corporate limits, write RURAL and give nearest town) WASHINGTON			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 7908 GLENDALE ROAD				STREET ADDRESS (If rural give location) 4337 VERPLANK PLACE, N.W.			
3. NAME OF DECEASED (Type or Print) ELIZABETH LOCKHART GADDIS				4. DATE OF DEATH (Month) FEB. (Day) 2 (Year) 1957			
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH 5/25/1869	9. AGE last birthday 87 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT DALTON				14. MOTHER'S MAIDEN NAME ELIZA HINES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS MRS ELIZABETH G. LOOKER 7908 GLENDALE RD., CHEVY CHASE, MD.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardio-vascular Renal Disease</u>						<u>5 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 14, 1956</u> to <u>Feb 3, 1957</u> that I last saw the deceased alive on <u>Feb 3, 1957</u> and that death occurred at <u>4:40 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>Sidney C. Bouvier</u>		DATE THEREOF <u>2/5/57</u>		NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		LOCATION (City, town, or county) <u>Washington, D.C.</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24. REC'D BY REGISTRAR <u>2-5-57</u>		REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W.</u>	
				ADDRESS <u>Wash, DC</u>			

BUREAU V. S.

FEB 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

019777

1974

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY U			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 8 Hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park			
f. STREET ADDRESS 250 Chinlee Drive				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Michele Middle Maria Last GAJEWSKI				4. DATE OF DEATH Month February Day 21 Year 1957			
5. SEX Female		6. COLOR OR RACE Cauc.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 20 Feb. 1957	
9. AGE (In years last birthday) yrs. 16		IF UNDER 1 YEAR Months 16 Days 30		IF UNDER 24 HRS. Hours 16 Min. 30			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Alfred Gajewski				14. MOTHER'S MAIDEN NAME Jeanette Maichette Snedeger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Official Navy Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hyaline Membrane Disease 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 174X DUE TO (c) Prematurity INTERVAL BETWEEN ONSET AND DEATH 16 hours							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 174X							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. p. Month 19 Day 19 Year 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 20 Feb. , 19 57 , to 21 Feb. , 19 57 , that I last saw the deceased alive on 21 Feb. , 19 57 , and that death occurred at 1:30A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 2-21-57							
ACTUAL SIGNATURE J.C. Parke				M.D. U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) J.C. PARKE, JR, LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-25-57		22c. NAME OF CEMETERY OR CREMATORY Holy Face Cemetery		22d. LOCATION (City, town, or county) (State) Great Mills, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robinson's Funeral Home, Leonardtown, Md.				24a. REC'D BY REGISTRAR DATE 2-23-57		24b. REGISTRAR'S SIGNATURE Nancy E. Russell	

RECEIVED

FEB 25 1967

BUREAU V. I.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

019784

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON c. LENGTH OF STAY IN 1b 2 weeks d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KENSINGTON GARDENS SANITARIUM		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 11,908 IVANHOE STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle C. Last GANLEY		4. DATE OF DEATH Month FEB. Day 3 Year 19 57	
5 SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/18/73
9. AGE (In years last birthday) 83 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEMAKER	11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN WILLIAMS	
14. MOTHER'S MAIDEN NAME unknown McNAMARA		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mrs. John H. Doffort, 11,908 Ivanhoe St. Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CARDIAC FAILURE 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (b) CHRONIC MYOCARDITIS (c) CHRONIC MYOCARDITIS DUE TO cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 hour several weeks			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. BROSCHART		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2/7/57	22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY	22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		24a. REC'D BY REGISTRAR 3/6/57 DATE 3/6/57	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Francis J. Toller	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

1957 11 18

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1976

CERTIFICATE OF DEATH

01979

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN 1b <u>DOA</u>		d. STREET ADDRESS <u>9 Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas M. GARRETT</u>		4. DATE OF DEATH Month Day Year <u>2 - 14 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/23/91</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>21</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Dairy Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Rockville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alexander Garrett</u>		14. MOTHER'S MAIDEN NAME <u>Mary Gaither</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-36-4169</u>	
17. INFORMANT <u>Mary G. King, Rockville, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>			
420.1 DUE TO <u>Myocardial Infarction</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Coronary Artery disease</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2042</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1953</u> , 19 <u>53</u> , to <u>2-17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-14</u> , 19 <u>57</u> , and that death occurred at <u>11:57</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm. G. Hall</u> M.D.		DATE SIGNED <u>2/16/57</u>	
PHYSICIAN'S NAME (Type) <u>Wm. G. Hall</u>		ADDRESS (Street, city or town, state) <u>615 W. Montg. Ave. Rockville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/16/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Union</u>	22d. LOCATION (City, town, or county) (State) <u>Rock. Montg. Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, 7557 Wis. Ave. Beth.</u>		24a. REC'D BY REGISTRAR <u>2-15-57</u> 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

BUREAU V. 1

FEB 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01980

1977

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8807 Hawkins Lane				d. STREET ADDRESS 8807 Hawkins Lane			
3. NAME OF DECEASED (Type or print) First Mary Middle E. Last Gassoway				4. DATE OF DEATH Month Feb. Day 16, Year 1957			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 29, 1876	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James H. Hawkins				14. MOTHER'S MAIDEN NAME Mary Jane Pinkney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT Ella C. Hawkins 8807 Hawkins Lane, Chevy Chase Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) metastatic adenocarcinoma liver DUE TO Primary CA probably GI tract (needle biopsy of liver) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 mo	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 2-16, 1956 , to 2-16, 1957 , that I last saw the deceased alive on 2-15, 1957 , and that death occurred at 7:30 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Dorothy Gill, M.D. 7511 Arlington Rd. Beth, Md. 2-19-57							
ACTUAL SIGNATURE Dorothy Gill, M.D.		PHYSICIAN'S NAME (Type) Dorothy Gill, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Shipped		22b. DATE THEREOF Feb. 21, 1957		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) York, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				ADDRESS Rockville, Maryland		24a. REC'D BY REGISTRAR DATE FEB 25 1957	
				24b. REGISTRAR'S SIGNATURE Lessie Thompson			

BUREAU V. S.

FEB 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01981

1978

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>4512 Gridley Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Sydia</u> Middle <u>Olive</u> Last <u>GATTIS</u>				4. DATE OF DEATH Month <u>2</u> Day <u>2</u> Year <u>1954</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-30-06</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>John E. Anderson</u>				14. MOTHER'S MAIDEN NAME <u>NANCY Ruth Wilkerson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Raymond (husband)</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis - Pulmonary Edema</u> DUE TO (b) <u>Ruptured Duodenal Ulcer</u> DUE TO (c) <u>Hypertension - Congestive H. Failure.</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>440X</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan. 29</u> , 19 <u>57</u> , to <u>Feb. 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb. 1</u> , 19 <u>57</u> , and that death occurred at <u>10:35</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>5953 Avon Drive, Bethesda, Md.</u>				DATE SIGNED <u>Feb. 2, 57</u>			
ACTUAL SIGNATURE <u>Alfred S. Norton</u>							
PHYSICIAN'S NAME (Type) <u>Alfred S. Norton</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 6, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery Fort Myer, Va.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Werner E. Humphrey</u> ADDRESS <u>Silver Spring, Md.</u>				24a. REC'D BY REGISTRAR <u>2-7-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 11 1957

BUREAU V. S.

1
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the police should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1919

CERTIFICATE OF DEATH

01982

Reg. Dist. No.

773

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7902 HOLSTEIN AVE.</u>		d. STREET ADDRESS <u>7902 HOLSTEIN ST.</u>	
3. NAME OF DECEASED (Type or print) <u>LOUISE Pauline GENTHER</u>		4. DATE OF DEATH <u>FEB. 4 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 29, 1888</u>
9. AGE (In years last birthday) <u>68</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
11. BIRTHPLACE (State or foreign country) <u>Patterson, New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ANTON STEHVKA</u>		14. MOTHER'S MAIDEN NAME <u>Pauline Tubner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>	
17. INFORMANT <u>HARRY K. GENTHER, SAME AS #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Congestion + Congestive Failure</u> DUE TO (b) <u>Arteriosclerotic Heart Dis. Auric. FIB</u> DUE TO (c) <u>Metastatic Carcinoma of Lung from</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>1-2 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Large Rndnt Ucler on side of face</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1956</u> , to <u>2/1/1957</u> that I last saw the deceased alive on <u>2/4/1957</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chas H McLothron</u>		DATE SIGNED <u>500 Underwood St NW Washington, D.C.</u>	
PHYSICIAN'S NAME (Type) <u>Chas H McLothron</u>		ADDRESS <u>Washington, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANSIT-BL RUL</u>		22b. DATE THEREOF <u>FEB 7, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LAUREL GROVE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PATTERSON, NEW JERSEY</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>		24a. REC'D BY REGISTRAR <u>13</u> DATE	
ADDRESS <u>254 Canal St NW SE</u>		24b. REGISTRAR'S SIGNATURE <u>J. Arthur Walters</u>	

RECEIVED
FEB. 7 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01983

1979

CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burtonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Estelle Esther Johnson Germann</u>				4. DATE OF DEATH Month <u>February</u> Day <u>2</u> Year <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/19/93</u>		9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Peregoy</u>				14. MOTHER'S MAIDEN NAME <u>Harriett Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Hospital Record</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bile Peritonitis</u> DUE TO <u>Chronic Cholelithiasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Cholecystitis</u> DUE TO <u>1/31/57</u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that I attended the deceased from <u>1/30/57</u> , 19 <u> </u> , to <u>2/2/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/2/57</u> , 19 <u>57</u> , and that death occurred at <u>3:00 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. W. Bird</u> M.D. <u>Sandy Spring, Md.</u>				ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u>			
PHYSICIAN'S NAME (Type) <u>J. W. Bird, M. D.</u>				Sandy Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Feb 5, 1957</u>		22b. DATE THEREOF <u>Feb 5, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		22d. LOCATION (City, town, or county) <u>Burtonsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u> ADDRESS <u>254 Carroll St N</u>				24a. RECEIVED BY REGISTRAR <u> </u> DATE <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Bertrude Lawler</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 4 1957

RECEIVED

1980

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Co.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>15 mins</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. STREET ADDRESS <u>5600 Namakgan Rd</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROSE-ETHEL</u> <u>GOVIER</u>				4. DATE OF DEATH Month Day Year <u>Feb.</u> <u>17</u> <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 30, 1891</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>DICE Newman</u>				14. MOTHER'S MAIDEN NAME <u>Julia Keppler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Niece - Mrs Neal - SAME</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Heart Disease</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Feb 12, 1957</u> , to <u>Feb 17, 1957</u> , that I last saw the deceased alive on <u>Feb 17, 1957</u> , and that death occurred at <u>5:25 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sidney E. Cousins</u> M.D. <u>3922 Lugomant 91W 2/17/57</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>SIDNEY E. COUSINS</u> <u>Wash. DC</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-20-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Blodgett, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u>				ADDRESS <u>4812 Gm Ave Mt</u>		24a. REC'D BY REGISTRAR <u>25 1057</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 41 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

EB 25 1957

RECEIVED

1981

CERTIFICATE OF DEATH

Reg. Dist. No.

211

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Clarksburg		c. LENGTH OF STAY IN 1b 12 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Clarksburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Arthur Homer Grace		4. DATE OF DEATH Month Feb. Day 8 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 22, 1902
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Gen Store	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Grace		14. MOTHER'S MAIDEN NAME Dora Alexandra	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-20-3929	
17. INFORMANT Eunice Grace		Address Clarksburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 12 Months 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1954 , to 8 Feb 1957 , that I last saw the deceased alive on 7 Feb 1957 , and that death occurred at 5:20 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Gordon Smith		ADDRESS (Street, city or town, state) Barthesville, Md. DATE SIGNED 8 Feb 57	
NAME (Type) Gordon Smith		Barthesville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/11/57	
22c. NAME OF CEMETERY OR CREMATORY End of Trail		22d. LOCATION (City, town, or county) (State) Rainelle, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber		ADDRESS Laytonsville, Md.	
24a. REC'D BY REGISTRAR Feb 11, 1957		24b. REGISTRAR'S SIGNATURE Deila O. Burdette	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ROBERT V. B.

1957



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1982

CERTIFICATE OF DEATH

01986

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY COUNTY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>ARLINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. LENGTH OF STAY IN 1b <u>5 MONTHS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAPLE LANE NURSING HOME</u>				d. STREET ADDRESS <u>5213 NO FAIRFAX DRIVE</u>			
3. NAME OF DECEASED (Type or print) First <u>CLARENCE</u> Middle <u>HEMING</u> Last <u>GREEN</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 13TH 1874</u>	9. AGE (In years lost birthday) <u>84</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gen. Accountant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Accounting (Ret)</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Thomas W. Green</u>			
14. MOTHER'S MAIDEN NAME <u>Liggott</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u> </u>				17. INFORMANT <u>Maple Lane Nursing Home (Records)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CHRONIC MYOCARDITIS</u> (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>						INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from <u>DEC 10, 1956</u> to <u>FEB 27, 1957</u> , that I last saw the deceased alive on <u>FEB 27, 1957</u> , and that death occurred at <u>2:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry A. Lowden</u>		M.D. <u>5306 NORWAY DR.</u>		DATE SIGNED <u>FEB 27, 1957</u>			
PHYSICIAN'S NAME (Type) <u>HENRY A. LOWDEN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/1/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Presbyterian Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hyndsham, Va.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arlington Funeral Home</u>		ADDRESS <u>3904 Fairfax Ave</u>		24a. REC'D BY REGISTRAR <u>5</u>	24b. REGISTRAR'S SIGNATURE <u>Frances Catter</u>		

RECEIVED

MAR 4 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1983

CERTIFICATE OF DEATH

01987

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) o. STATE Georgia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 3 mos. 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Gaines	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS None given		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edward Middle Alonzo Last GREENE				4. DATE OF DEATH Month February Day 23 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 August 1875		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps		10b. KIND OF BUSINESS OR INDUSTRY USMC (Retired)		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William James Greene				14. MOTHER'S MAIDEN NAME Caroline W. Morris			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-I		17. INFORMANT Official Navy Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized metastatic carcinoma 199.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Squamous cell carcinoma, maxilla & palate DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 8 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 14 Nov. , 19 56 , to 23 Feb. , 19 57 , that I last saw the deceased alive on 23 Feb. , 19 57 , and that death occurred at 08:40A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Francis J. Sweeney M.D. U.S. Naval Hospital, Bethesda, Md. 2--25-57 PHYSICIAN'S NAME (Type) Francis J. Sweeney, LCDR, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 29 Feb. 57		22c. NAME OF CEMETERY OR CREMATORY Fort Gaines Cemetery		22d. LOCATION (City, town, or county) (State) Clay County, Georgia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 2-24-57		24b. REGISTRAR'S SIGNATURE Barry C. Parrelly	

BUREAU V. S.

FEB 105.

RECEIVED

1984

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY <u>Montg.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Geithersburg</u>				c. LENGTH OF STAY IN 1b <u>10 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Geithersburg</u>			
				f. STREET ADDRESS <u>9 Cedar Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Martin</u> Last <u>Hackel</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 6, 1877</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS	
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Months <u>1</u> Days <u>11</u> Hours <u></u> Min <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired machinist for U.S. Government</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Co., Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Joseph Hackel</u>				14. MOTHER'S MAIDEN NAME <u>Mary C. Bolen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u></u>			
				17. INFORMANT <u>Lola C. Hackel</u> Address <u>Geithersburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> INTERVAL BETWEEN ONSET AND DEATH <u>7 DAYS</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIAL HYPERTENSION</u> <u>20 YEARS</u>							
(c) <u>ARTERIO SCLEROSIS</u> <u>20 YEARS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>FEB 17, 1957</u> , to <u>FEB 17, 1957</u> , that I last saw the deceased alive on <u>FEBRUARY 16, 1957</u> , and that death occurred at <u>10 A.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Geithersburg, Md.</u> DATE SIGNED <u>Feb 17/57</u>							
ACTUAL SIGNATURE <u>Ernest C. Gartner</u> M.D.				26. REGISTRAR'S SIGNATURE <u>Abraham S. Cooke</u>			
PHYSICIAN'S NAME (Type) <u>Geithersburg, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-20-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Towson Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner</u> ADDRESS <u>Geithersburg</u>				24a. REC'D BY REGISTRAR <u>Feb 2-19-57</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 25 1957

BUREAU V. M.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01989

1985

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>2 days</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Lee</u> Last <u>Hall</u>			4. DATE OF DEATH Month <u>February</u> Day <u>17</u> Year <u>57</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>27 December 1920</u>		9. AGE (In years, lost birthday) <u>36</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Government Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NAVY DEPT. Government</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
13. FATHER'S NAME <u>John W. Hall</u>			14. MOTHER'S MAIDEN NAME <u>Ada Miller</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>236-18-2320</u>		17. INFORMANT <u>The Medical Record, Clinical Center</u> <u>National Institutes of Health, Bethesda 14, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>04.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>acute leukemia</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>5-6 hrs.</u> <u>4-6 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Hour <u>a. 11</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____
20f. (City or town) _____			20g. (County) _____ (State) _____		
21. I certify that I attended the deceased from <u>15 February, 1957</u> to <u>17 February, 1957</u> , that I last saw the deceased alive on <u>17 February</u> , 1957, and that death occurred at <u>7:10 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Gurston Goldin</u>			ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>2/13/57</u>		
PHYSICIAN'S NAME (Type) <u>Gurston Goldin, M. D.</u>			M.D. <u>The Clinical Center</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/20/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>	
22d. LOCATION (City, town, or county) <u>ARLINGTON, VIRGINIA</u>		(State) _____			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner B. Pumphrey</u>			ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>2-20-57</u>
24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

73 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01990

1986

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 14, Md.</u>		c. LENGTH OF STAY IN 1b <u>131 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		d. STREET ADDRESS <u>106 Beall Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Hertha</u> Middle <u>Catherine</u> Last <u>Hamann</u>		4. DATE OF DEATH Month <u>February</u> Day <u>17</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 20, 1898</u>
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>27</u>	IF UNDER 24 HRS Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Publishing Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Herman Jonas</u>		14. MOTHER'S MAIDEN NAME <u>Dora Steinfelt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>060-01-3213</u>	
17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Breast</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>110X</u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 9, 1956</u> to <u>February 17, 1957</u> , that I last saw the deceased alive on <u>February 17, 1957</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard R. Engel</u>		ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Howard R. Engel, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>2/17/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland Prince Geo. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY, 7557 Wisc. Ave. Beth</u>		24a. REC'D BY REGISTRAR <u>20-57</u> 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

BUREAU V. S.

FEB 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar, and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01991

1987 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Washington 47x	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 514 19th St., N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bessie Middle Martin Last HAMBERGER		4. DATE OF DEATH Month FEBRUARY Day 19 Year 19 57	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 July 1875
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME De Witt Clinton Ellis		14. MOTHER'S MAIDEN NAME Mary Janette Hays	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT (Son) DeWitt C.E. Hamberger		Address Washington, D. C. 2401 Calvert St., N.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Embolism DUE TO Carcinoma, sigmoid colon with metastases		INTERVAL BETWEEN ONSET AND DEATH 10 days 21 days 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 15 Dec. , 19 56 , to 19 Feb. , 19 57 , that I last saw the deceased alive on 18 Feb. , 19 57 , and that death occurred at 03:19A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 2-19-57			
ACTUAL SIGNATURE George W. Russell M.D.			
PHYSICIAN'S NAME (Type) George W. Russell, Capt, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-21-57	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Gawler's & Sons		24a. REC'D BY REGISTRAR 2-19-57	
ADDRESS Gawler's & Sons, 1756 Penn. Ave., Washington, D.C.		24b. REGISTRAR'S SIGNATURE George W. Russell	

BUREAU V. S.

FEB 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01992

1988

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Lubaban</u>		d. STREET ADDRESS <u>H 231 Jennifer St. NW</u>	
3. NAME OF DECEASED (Type or print) First <u>Mattie</u> Middle <u>E.</u> Last <u>Idand</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>11</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 9 1893</u>
9. AGE (In years, last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>19</u> Hours <u>57</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas E. Wright</u>		14. MOTHER'S MAIDEN NAME <u>Martha Blair</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>William A. Idand</u>		Address <u>-</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis of abdomen & lungs</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Adenocarcinoma of ascending colon</u> DUE TO (c) <u>-</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>	
20c. TIME OF INJURY Hour <u>a. 1.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> p. m. <u>-</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>		20f. (City or town) <u>-</u> (County) <u>-</u> (State) <u>-</u>	
21. I certify that I attended the deceased from <u>Feb 10</u> , 19 <u>57</u> , to <u>Feb 11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 10</u> , 19 <u>57</u> , and that death occurred at <u>12:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stewart Clapp</u>		M.D. <u>3421 Ingomar St NW</u>	
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>		<u>Washington DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/14/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) <u>Bethesda MD</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chung Chuan Fung</u>		ADDRESS <u>Home, 5103 Kirkwood</u>	
24a. REC'D BY REGISTRAR <u>2-14-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bruce M. Thompson</u>	

BUREAU V. S.

FEB

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01993
213

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dickerson</u> c. LENGTH OF STAY IN 1b <u>20 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.F.U.</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x1 Dickerson</u> d. STREET ADDRESS <u>R.F.U.</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <u>Relda</u> Middle <u>Havenner</u> Last <u>Havenner</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>15</u> Year <u>1957</u>													
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-18-77</u>		9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>				11. BIRTHPLACE (State or foreign country) <u>Va</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Judd Presgroves</u>						14. MOTHER'S MAIDEN NAME <u>Jimmy Havenner</u>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)				17. INFORMANT Name <u>Geo Cockrill</u> Address <u>Herndon Va</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u>Fond dead in bed</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year <u> </u> <u> </u> <u> </u> 19 <u> </u> Hour <u> </u> o. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																	
ACTUAL SIGNATURE <u>Frank J Broschant</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED					
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						<u>2-15-57</u>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>						22b. DATE THEREOF <u>2/17/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Shelvington</u>		22d. LOCATION (City, town, or county) <u>Va</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Berkley Green-Herndon</u>						ADDRESS <u>Va</u>						24a. REC'D BY REGISTRAR <u>2/6/57</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Blinn</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

REAU V. 3

FEB 17 1957

RECEIVED

1990

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montg</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>418 Horners Lane</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ary Case Hawkins</u>		4. DATE OF DEATH Month Day Year <u>Feb 23 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 2-1877</u>
9. AGE (In years last birthday) <u>79 yrs.</u>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Montg. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Richard Case</u>		14. MOTHER'S MAIDEN NAME <u>ary Federline</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Virginia Waters, Gaithersburg.</u>		Address	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac decompensation</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Cerebrovascular accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>30 yrs</u> <u>5 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1954-19</u> , to <u>2-23</u> , 1957, that I last saw the deceased alive on <u>2-13</u> , 1957, and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>W. G. Hall</u> M.D. <u>615 N. Montgomery Ave. Rockville, Md.</u> <u>2/23/57</u>			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <u>W. G. Hall</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>2-26-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>		22d. LOCATION (City, town, or county) (State) <u>Beallsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner.</u>		ADDRESS <u>Gaithersburg, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>2/26/57</u>		24b. REGISTRAR'S SIGNATURE <u>Laurel Kragtorp</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
FEB 1 1957
BUREAU V. S.

1991

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 5 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Merritt Last HEAZLIT Jr.				4. DATE OF DEATH Month February Day 11 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 Feb. 1957	9. AGE (In years last birthday) 5 yrs	IF UNDER 1 YEAR Months 5 Days 5 Hours 5 Min.	12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Merritt Heazlit Sr.				14. MOTHER'S MAIDEN NAME Elizabeth Jane Spacey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Official Navy Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGENITAL ATELECTASIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PULMONARY HYALINE MEMBRANE DUE TO (c) 5 days							INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. 11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6 February , 19 57 , to 11 Feb. , 19 57 , that I last saw the deceased alive on 11 Feb. , 19 57 , and that death occurred at 1:20 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Daniel Shuptar		ADDRESS (Street, city or town, state) U.S. Naval Hospital, NNMC, Beth. Md. DATE SIGNED 2-12-57					
PHYSICIAN'S NAME (Type) Daniel Shuptar, LT, USN		U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 2-15-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey		ADDRESS Funeral Home, 1557 Wisconsin Ave.		24a. REC'D BY REGISTRAR DATE 2-12-57		24b. REGISTRAR'S SIGNATURE Bray E. Russell	

TO POSTERIOR OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1977

1977

1992

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>District of Columbia</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN 1b <u>34 hours</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Maryland</u>				d. STREET ADDRESS <u>1823 Ft. Davis St.,</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>Marie</u> Last <u>HERBER</u>				4. DATE OF DEATH Month <u>February</u> Day <u>25</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>23 Feb. 1957</u>	
9. AGE (In years lost birthday) yrs <u>1</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>10</u> Hours <u>10</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>David Lewis Herber</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jean Pratico</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO (If yes, give year or dates of service) <u>None</u>		17. INFORMANT Address (Father) <u>David L. Herber, (Same as #2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral primary atelectasis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>34 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. 51.</u> Month <u>19</u> Day <u>19</u> Year <u>19 57</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>23 Feb.</u> , 19 <u>57</u> , to <u>25 Feb.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>25 Feb.</u> , 19 <u>57</u> , and that death occurred at <u>3:15A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Daniel Shumtar</u>				ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Daniel Shumtar, LT, MC, USN</u>				DATE SIGNED <u>2-25-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>27 Feb. 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William G. K. Mettingly</u>				ADDRESS <u>Washington, D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>2-25-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary E. Tassell</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 27 1957

RECEIVED

1920

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park 12</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>57 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanatorium and Hosp.</u>		d. STREET ADDRESS <u>3704 Everton ST.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Baby Boy</u>		4. DATE OF DEATH Month <u>2</u> Day <u>1</u> Year <u>1957</u>	
5. SEX <u>Boy</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/31/57</u>
9. AGE (In years last birthday) <u>0</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>10</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>Herbert Paul Hoover</u>		14. MOTHER'S MAIDEN NAME <u>Davine Thorpe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis & Prematurity</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 Hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-31-57</u> , 19 <u>57</u> , to <u>2-1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-31</u> , 19 <u>57</u> , and that death occurred at <u>2:53</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Warren C. Preisser</u> M.D.		ADDRESS (Street, city or town, state) <u>8418 N. H. Ave Silver Spring Md.</u>	
DATE SIGNED <u>2/1/57</u>			
PHYSICIAN'S NAME (Type) <u>WARREN C. PREISSER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<u>Burial</u>		<u>Feb 2 - 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Leo. Washington Gen. Burial Co. Md.</u>		<u>Prince Georges Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Halton</u>		ADDRESS <u>254 Carroll St.</u>	
DATE <u>1957</u>		24. REC'D BY REGISTRAR <u>J. Wilson Dodd</u>	

22075:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 9 1957

BUREAU V. S.

1993

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARTIN William HosseibARTH</u>		4. DATE OF DEATH Month Day Year <u>2 - 6 19 57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-7-05</u>
9. AGE (In years lost birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. Government</u>	
11. BIRTHPLACE (State or foreign country) <u>New York City</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William CURT HOSSEIBARTH</u>		14. MOTHER'S MAIDEN NAME <u>FRANCES Agnes SEUFFERT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MARGARET (wife)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SUBARACHNOID HEMORRAGE</u> <u>330X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE CONGENITAL ANEURYSM</u> DUE TO (c) <u>FROM BIRTH</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1/11</u> , 19 <u>57</u> , to <u>2/6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/6</u> , 19 <u>57</u> , and that death occurred at <u>935 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>9300 EWING DR. BETHESDA, MD.</u> DATE SIGNED <u>2/6/57</u>			
ACTUAL SIGNATURE <u>Seymour Greenbaum</u> M.D.		PHYSICIAN'S NAME (Type) <u>SEYMOUR GREENBAUM, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/9/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Epiphany Episcopal Church Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Forestville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles B. Humphrey</u>		24a. REC'D BY REGISTRAR <u>2-12-57</u>	24b. REGISTRAR'S SIGNATURE <u>Rebecca M. Thompson</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 4

S. A. DAVIS

1937

DEPT.

1921
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 27 Hrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE b. COUNTY District of Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 7060 Eastern Avenue N. W. d. STREET ADDRESS 7060 Eastern Avenue N. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Dewey George Humphries		4. DATE OF DEATH Month Day Year February 10 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-3-98
9. AGE (In years last birthday) 59		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bakery Helper		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME George Humphries		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) WWI ?		16. SOCIAL SECURITY NO. 224-09-8937	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infant of myocardium, antecystic DUE TO Thrombosis, antecystic branch L. Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. and Infant of myocardium, po PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 week int. "	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 8 , 1957, to Feb 10 , 1957, that I last saw the deceased alive on Feb 9 , 1957, and that death occurred at 3:10 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 401 Kennedy St NW Wash DC DATE SIGNED 2/10/57 ACTUAL SIGNATURE M. F. Ottman M.D. PHYSICIAN'S NAME (Type) M. F. OTTMAN			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/13/57	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Ft. Myer Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co.		24a. REC'D BY REGISTRAR 12 1957	
ADDRESS 1400 Chapin St NW Wash, D.C.		24b. REGISTRAR'S SIGNATURE John A. D. G.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

73 12 1957

RECEIVED

1929

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1 PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) Waverley Sanitarium				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase			
f. STREET ADDRESS 5302 Newport Ave.				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lincoln Middle HUMPHREYS Last				4. DATE OF DEATH Month February Day 22 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 12, 1891	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months 10 Days 10	IF UNDER 24 HRS Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. US Navy		10b. KIND OF BUSINESS OR INDUSTRY Doctor		11. BIRTHPLACE (State or foreign country) Arkansas		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Charles Jones Humphreys				14. MOTHER'S MAIDEN NAME Anne Dick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) WW yes		16. SOCIAL SECURITY NO. WW 1 & 11		17. INFORMANT Richard Solon Humphreys-Item# 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, Cerebral DUE TO (c) Arteriosclerosis Generalized						INTERVAL BETWEEN ONSET AND DEATH 2 mos. 6 yrs. 6 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Dec 25, 1956 , to Feb 22, 1957 , that I last saw the deceased alive on Feb 22, 1957 , and that death occurred at 3:10 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Joseph H. Watson				ADDRESS (Street, city or town, state) 1822 Biltmore St. N.W., Wash. D.C.			
PHYSICIAN'S NAME (Type) Joseph H. Watson				DATE SIGNED Feb 22, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/26/57		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 23 57		24b. REGISTRAR'S SIGNATURE W. A. M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
FEB 23 1957
TEAU V. S.

1930

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		
c. LENGTH OF STAY IN 1b <u>4 days</u>			d. STREET ADDRESS <u>4227 Roundhill Road</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Congressional Minor San.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Hutsko</u> Last <u>Hutsko</u>			4. DATE OF DEATH Month <u>Feb</u> Day <u>17</u> Year <u>1957</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>9-24-1903</u>		9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <u>Austria</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Adamesko</u>			14. MOTHER'S MAIDEN NAME <u>Mary</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <u>Andrew Hock, Jr.</u>			Address <u>Wheaton, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Tumor - of the</u> <u>IX</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>corpus callosum</u> DUE TO (c) <u>Unknown</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Dec. 30, 1956</u> to <u>Feb. 15, 1957</u> , that I last saw the deceased alive on <u>Feb. 15, 1957</u> , and that death occurred at <u>5:30 A.M.</u> , from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) DATE SIGNED.					
ACTUAL SIGNATURE <u>Philip C. Jones</u> M.D. <u>918 Ellsworth Drive Silver Spring</u>					
NAME (Type) <u>Philip E. Jones</u> <u>Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
<u>BURIAL</u>		<u>2-19-1957</u>		<u>ST JOHNS CEMETERY SCRANTON, PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE			24b. REGISTRAR'S SIGNATURE		
<u>W.W. CHAMBERS CO 1400 CHAPIN ST BAL</u>			<u>Samuel Knight</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
U. S. DEPT. OF JUSTICE

NOV 10 1907

1994

CERTIFICATE OF DEATH

Reg. Dist. No.

02002

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Redland c. LENGTH OF STAY IN 1b 51 Yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) X2 d. STREET ADDRESS Derwood, Rt. 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LOUIS G. JOHNSON First Middle Last				4. DATE OF DEATH Feb. 11, 1957 Month Day Year			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/29/1859	9. AGE (In years last birthday) 97 yrs	IF UNDER 1 YEAR Months 4 Days 12 Hours Min. 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoemaker				10b. KIND OF BUSINESS OR INDUSTRY Shoe Shop		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Robert G. Johnson			
14. MOTHER'S MAIDEN NAME Mary Lovejoy				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. none				17. INFORMANT Mrs. Chinton Earp, Derwood, Maryland Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 						INTERVAL BETWEEN ONSET AND DEATH 2 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 28, 1956 , to Feb 11, 1957 , that I last saw the deceased alive on Feb 10, 1957 , and that death occurred at 12:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rockville, Md. DATE SIGNED 2/11/57 ACTUAL SIGNATURE Stephen C. Cromwell M.D. PHYSICIAN'S NAME (Type) Stephen C. Cromwell Rockville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/14/57		22c. NAME OF CEMETERY OR CREMATORY Forest Oak		22d. LOCATION (City, town, or county) (State) Gaithersburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS 1557 Wisc. Ave. Beth				24a. REC'D BY REGISTRAR DATE 2/14/57		24b. REGISTRAR'S SIGNATURE Laurel Kragtorp <i>per sec</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02003

1995

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 14, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg, Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>SUBURBAN Hosp.</u>		d. STREET ADDRESS <u>431 - FREDRICK AVE.</u>	
3. NAME OF DECEASED (Type or print) <u>Catherine</u>		4. DATE OF DEATH <u>Feb-25-1957</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-16-1872</u>	
9. AGE (In years last birthday) <u>84</u> Yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if faded) <u>House-wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Schuylkill Co. Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Pos. no. or unknown) <u>no</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>Geo. H. Wilson - 10420-14th St. N.W. DC.</u>	
17. INFORMANT <u>Grandson</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO <u>Cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rt Pulmonary Infarction - A.S.H.D.</u> (c) <u>Bronchopneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-19-57</u> to <u>2-25-57</u> , that I last saw the deceased alive on <u>2-25-57</u> and that death occurred at <u>3:35 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George A. Gray, Jr</u> M.D.		DATE SIGNED <u>2/28/57</u>	
PHYSICIAN'S NAME (Type) <u>George A. Gray, Jr</u>		ADDRESS <u>Cherry Chase, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/1/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>-</u>		22d. LOCATION (City, town, or county) (State) <u>Fountain Springs, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chamber Co</u> ADDRESS <u>1400 Chapin St. Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>28 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>			

RECEIVED

NOV 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1996 CERTIFICATE OF DEATH

02004

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 323 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
		d. STREET ADDRESS 3410 Roselawn Avenue	
3. NAME OF DECEASED (Type or print) First Edith Middle Krakow Last Jones		4. DATE OF DEATH Month February Day 26 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 January 1895
9. AGE (In years last birthday) yrs 62		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward H. Krakow		14. MOTHER'S MAIDEN NAME Fredericka Wendt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 500-36-6992	
17. INFORMANT The Medical Record, Clinical Center, National Institutes of Health, Bethesda 14, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF BREAST METASTATIC TO LUNG, PLEURA, BRAIN, BONE, ADRENAL 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) RHEUMATIC HEART DISEASE; MITRAL + AORTIC STENOSIS INTERVAL BETWEEN ONSET AND DEATH 4 1/2 YRS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. ft. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 30 January , 19 56 , to 26 February , 19 57 , that I last saw the deceased alive on 26 February , 19 57 , and that death occurred at 9:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Samuel Charache M.D.		The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) Samuel Charache, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/2/57	22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park	22d. LOCATION (City, town, or county) (State) Taylor Ave. Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc		ADDRESS 6009 Hayford Rd	
24a. REC'D BY REGISTRAR 4		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

BUREAU V. S.

NOV 5 1907

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO VITAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02005

1997

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton Glenmont</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton Glenmont</u>			
c. LENGTH OF STAY IN 1b <u>years</u>				x2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>12117 Georgia Avenue</u>				e. STREET ADDRESS <u>12117 Georgia Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>WADE</u> Middle <u>HAMPTON</u> Last <u>JONES</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 29, 1876</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR: Months <u>80</u> Days <u>28</u> Hours <u>19</u> Min. <u>57</u>		IF UNDER 24 HRS: Months <u>80</u> Days <u>28</u> Hours <u>19</u> Min. <u>57</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber-Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing</u>			
11. BIRTHPLACE (State or foreign country) <u>GLENMONT, MONTGOMERY, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>SAMUEL H. JONES</u>				14. MOTHER'S MAIDEN NAME <u>ELLEN L'ENABLE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>none</u>			
17. INFORMANT <u>Garrett D. Incoe, Jr. Collesville, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> 477 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>10-12-20</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. 11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1947</u> to <u>2/28</u> 1957, that I last saw the deceased alive on <u>1/15</u> 1957, and that death occurred at <u>1 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>9006 Collesville Rd. Silver Spring, Md.</u> DATE SIGNED <u>March 3, 1957</u>							
ACTUAL SIGNATURE <u>William D. And</u> M.D. <u>9006 Collesville Rd</u>							
PHYSICIAN'S NAME (Type) <u>William D. And</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAR 2, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenmont Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>GOLESVILLE, MONTGOMERY, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James P. Halling</u> ADDRESS <u>WASH DC 254 CARROLL ST NW</u>				24. REC'D BY REGISTRAR <u>James P. Halling</u> DATE <u>MAR 3 1957</u>			
25. REGISTRAR'S SIGNATURE <u>James P. Halling</u>				26. REGISTRAR'S SIGNATURE <u>James P. Halling</u>			

BUREAU V. S.

1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1998 CERTIFICATE OF DEATH

02006

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>10604 Wheatley</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Miss Lois Anne Kahler</u>				4. DATE OF DEATH Month Day Year <u>2 18 1957</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-4-1925</u>			
9. AGE (In years last birthday) yrs. <u>31</u>		IF UNDER 1 YEAR Months Days Hours Min <u>2 14</u>		IF UNDER 24 HRS. <u>2 14</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk-typist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Pasadena, Calif</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>Herbert Kahler</u>				14. MOTHER'S MAIDEN NAME <u>Thera Emerson</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, (a) or (b) or (c) or (d) or (e) or (f) or (g) or (h) or (i) or (j) or (k) or (l) or (m) or (n) or (o) or (p) or (q) or (r) or (s) or (t) or (u) or (v) or (w) or (x) or (y) or (z) or (aa) or (ab) or (ac) or (ad) or (ae) or (af) or (ag) or (ah) or (ai) or (aj) or (ak) or (al) or (am) or (an) or (ao) or (ap) or (aq) or (ar) or (as) or (at) or (au) or (av) or (aw) or (ax) or (ay) or (az) or (ba) or (bb) or (bc) or (bd) or (be) or (bf) or (bg) or (bh) or (bi) or (bj) or (bk) or (bl) or (bm) or (bn) or (bo) or (bp) or (bq) or (br) or (bs) or (bt) or (bu) or (bv) or (bw) or (bx) or (by) or (bz) or (ca) or (cb) or (cc) or (cd) or (ce) or (cf) or (cg) or (ch) or (ci) or (cj) or (ck) or (cl) or (cm) or (cn) or (co) or (cp) or (cq) or (cr) or (cs) or (ct) or (cu) or (cv) or (cw) or (cx) or (cy) or (cz) or (da) or (db) or (dc) or (dd) or (de) or (df) or (dg) or (dh) or (di) or (dj) or (dk) or (dl) or (dm) or (dn) or (do) or (dp) or (dq) or (dr) or (ds) or (dt) or (du) or (dv) or (dw) or (dx) or (dy) or (dz) or (ea) or (eb) or (ec) or (ed) or (ee) or (ef) or (eg) or (eh) or (ei) or (ej) or (ek) or (el) or (em) or (en) or (eo) or (ep) or (eq) or (er) or (es) or (et) or (eu) or (ev) or (ew) or (ex) or (ey) or (ez) or (fa) or (fb) or (fc) or (fd) or (fe) or (ff) or (fg) or (fh) or (fi) or (fj) or (fk) or (fl) or (fm) or (fn) or (fo) or (fp) or (fq) or (fr) or (fs) or (ft) or (fu) or (fv) or (fw) or (fx) or (fy) or (fz) or (ga) or (gb) or (gc) or (gd) or (ge) or (gf) or (gg) or (gh) or (gi) or (gj) or (gk) or (gl) or (gm) or (gn) or (go) or (gp) or (gq) or (gr) or (gs) or (gt) or (gu) or (gv) or (gw) or (gx) or (gy) or (gz) or (ha) or (hb) or (hc) or (hd) or (he) or (hf) or (hg) or (hh) or (hi) or (hj) or (hk) or (hl) or (hm) or (hn) or (ho) or (hp) or (hq) or (hr) or (hs) or (ht) or (hu) or (hv) or (hw) or (hx) or (hy) or (hz) or (ia) or (ib) or (ic) or (id) or (ie) or (if) or (ig) or (ih) or (ii) or (ij) or (ik) or (il) or (im) or (in) or (io) or (ip) or (iq) or (ir) or (is) or (it) or (iu) or (iv) or (iw) or (ix) or (iy) or (iz) or (ja) or (jb) or (jc) or (jd) or (je) or (jf) or (jg) or (jh) or (ji) or (jj) or (jk) or (jl) or (jm) or (jn) or (jo) or (jp) or (jq) or (jr) or (js) or (jt) or (ju) or (jv) or (jw) or (jx) or (jy) or (jz) or (ka) or (kb) or (kc) or (kd) or (ke) or (kf) or (kg) or (kh) or (ki) or (kj) or (kk) or (kl) or (km) or (kn) or (ko) or (kp) or (kq) or (kr) or (ks) or (kt) or (ku) or (kv) or (kw) or (kx) or (ky) or (kz) or (la) or (lb) or (lc) or (ld) or (le) or (lf) or (lg) or (lh) or (li) or (lj) or (lk) or (ll) or (lm) or (ln) or (lo) or (lp) or (lq) or (lr) or (ls) or (lt) or (lu) or (lv) or (lw) or (lx) or (ly) or (lz) or (ma) or (mb) or (mc) or (md) or (me) or (mf) or (mg) or (mh) or (mi) or (mj) or (mk) or (ml) or (mm) or (mn) or (mo) or (mp) or (mq) or (mr) or (ms) or (mt) or (mu) or (mv) or (mw) or (mx) or (my) or (mz) or (na) or (nb) or (nc) or (nd) or (ne) or (nf) or (ng) or (nh) or (ni) or (nj) or (nk) or (nl) or (nm) or (nn) or (no) or (np) or (nq) or (nr) or (ns) or (nt) or (nu) or (nv) or (nw) or (nx) or (ny) or (nz) or (oa) or (ob) or (oc) or (od) or (oe) or (of) or (og) or (oh) or (oi) or (oj) or (ok) or (ol) or (om) or (on) or (oo) or (op) or (oq) or (or) or (os) or (ot) or (ou) or (ov) or (ow) or (ox) or (oy) or (oz) or (pa) or (pb) or (pc) or (pd) or (pe) or (pf) or (pg) or (ph) or (pi) or (pj) or (pk) or (pl) or (pm) or (pn) or (po) or (pp) or (pq) or (pr) or (ps) or (pt) or (pu) or (pv) or (pw) or (px) or (py) or (pz) or (qa) or (qb) or (qc) or (qd) or (qe) or (qf) or (qg) or (qh) or (qi) or (qj) or (qk) or (ql) or (qm) or (qn) or (qo) or (qp) or (qq) or (qr) or (qs) or (qt) or (qu) or (qv) or (qw) or (qx) or (qy) or (qz) or (ra) or (rb) or (rc) or (rd) or (re) or (rf) or (rg) or (rh) or (ri) or (rj) or (rk) or (rl) or (rm) or (rn) or (ro) or (rp) or (rq) or (rr) or (rs) or (rt) or (ru) or (rv) or (rw) or (rx) or (ry) or (rz) or (sa) or (sb) or (sc) or (sd) or (se) or (sf) or (sg) or (sh) or (si) or (sj) or (sk) or (sl) or (sm) or (sn) or (so) or (sp) or (sq) or (sr) or (ss) or (st) or (su) or (sv) or (sw) or (sx) or (sy) or (sz) or (ta) or (tb) or (tc) or (td) or (te) or (tf) or (tg) or (th) or (ti) or (tj) or (tk) or (tl) or (tm) or (tn) or (to) or (tp) or (tq) or (tr) or (ts) or (tt) or (tu) or (tv) or (tw) or (tx) or (ty) or (tz) or (ua) or (ub) or (uc) or (ud) or (ue) or (uf) or (ug) or (uh) or (ui) or (uj) or (uk) or (ul) or (um) or (un) or (uo) or (up) or (uq) or (ur) or (us) or (ut) or (uu) or (uv) or (uw) or (ux) or (uy) or (uz) or (va) or (vb) or (vc) or (vd) or (ve) or (vf) or (vg) or (vh) or (vi) or (vj) or (vk) or (vl) or (vm) or (vn) or (vo) or (vp) or (vq) or (vr) or (vs) or (vt) or (vu) or (vv) or (vw) or (vx) or (vy) or (vz) or (wa) or (wb) or (wc) or (wd) or (we) or (wf) or (wg) or (wh) or (wi) or (wj) or (wk) or (wl) or (wm) or (wn) or (wo) or (wp) or (wq) or (wr) or (ws) or (wt) or (wu) or (wv) or (ww) or (wx) or (wy) or (wz) or (xa) or (xb) or (xc) or (xd) or (xe) or (xf) or (xg) or (xh) or (xi) or (xj) or (xk) or (xl) or (xm) or (xn) or (xo) or (xp) or (xq) or (xr) or (xs) or (xt) or (xu) or (xv) or (xw) or (xx) or (xy) or (xz) or (ya) or (yb) or (yc) or (yd) or (ye) or (yf) or (yg) or (yh) or (yi) or (yj) or (yk) or (yl) or (ym) or (yn) or (yo) or (yp) or (yq) or (yr) or (ys) or (yt) or (yu) or (yv) or (yw) or (yx) or (yy) or (yz) or (za) or (zb) or (zc) or (zd) or (ze) or (zf) or (zg) or (zh) or (zi) or (zj) or (zk) or (zl) or (zm) or (zn) or (zo) or (zp) or (zq) or (zr) or (zs) or (zt) or (zu) or (zv) or (zw) or (zx) or (zy) or (zz)		16. SOCIAL SECURITY NO. <u>216-22-1588</u>		17. INFORMANT <u>Herbert Kahler</u> Address <u>Kensington 10604 Wheatley St -</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal Obstruction</u> <u>570.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Volvulus, jejunum</u> DUE TO (c) <u>Adhesions</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 days</u> <u>few weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>thrombosis left iliac & femoral Arteries</u>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)		20h. (State)			
21. I certify that I attended the deceased from <u>2/6</u> , 19 <u>57</u> , to <u>2/18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/17/57</u> , and that death occurred at <u>74</u> M, from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Arch L. Riddick</u> M.D.				ADDRESS (Street, city or town, state) <u>8512 Old Georgetown Rd. Bethesda, Md</u> DATE SIGNED <u>2/18/57</u>					
PHYSICIAN'S NAME (Type) <u>Arch L. Riddick</u>				ADDRESS <u>8512 Old Georgetown Rd. Bethesda, Md</u>					
22a. BURIAL, CREMAT. OR REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/20/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Union</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Montg. Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Cunningham - Bethesda Md.</u>				24a. REC'D BY REGISTRAR DATE <u>2-20-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

RECEIVED

FEB 25 1957

BUREAU

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
 TO PUBLIC HEALTH DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1999 CERTIFICATE OF DEATH

02007

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Florida</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 14, Maryland</u>				c. LENGTH OF STAY IN 1b <u>64 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>NATIONAL INSTITUTE OF HEALTH</u>				d. STREET ADDRESS <u>1060 Northwest 7th Street</u>			
3. NAME OF DECEASED (Type or print) <u>Victoria</u> First Middle Last <u>(none)</u> <u>Kermisch</u>				4. DATE OF DEATH <u>February 12</u> 19 <u>57</u> Month Day Year			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 17, 1890</u>	9. AGE (In years, last birthday) <u>66</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Austria</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Aaron Frankel</u>				14. MOTHER'S MAIDEN NAME <u>? Cilli</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) <u>No</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO <u>unknown</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary embolus</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>December 10, 1956</u> , to <u>February 12, 1957</u> , that I last saw the deceased alive on <u>February 12</u> , 19 <u>57</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Roy Vagelos</u> M.D.				ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>2/13/57</u>			
PHYSICIAN'S NAME (Type) <u>Roy Vagelos, M. D.</u>				National Institutes of Health <u>Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-15-57</u>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>Miami</u> <u>Florida</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don. DeVol-2224-Wis. Ave N.W. #4</u>				24a. REC'D BY REGISTRAR <u>2-16-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

RECEIVED

NOV 19 1957

RECEIVED

TO VITAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2000

CERTIFICATE OF DEATH

02008/4

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived (If institution: Residence before admission)) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHEATON, MD.				c. LENGTH OF STAY IN 1b 7 MONTHS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —				d. STREET ADDRESS 11409 MONTERRY DR			
3. NAME OF DECEASED (Type or print) Elizabeth Ceelia Kiernan				4. DATE OF DEATH Month 2 Day 2 Year 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-13-1894	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINT. WORKER		10b. KIND OF BUSINESS OR INDUSTRY CITY COURT HOUSE NEW YORK	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME GOLDEN		14. MOTHER'S MAIDEN NAME MARY C	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 152-20-5840		17. INFORMANT PATRICK KIERNAN WHEATON, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 463X DUE TO Thrombo-phlebitis left leg Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____				INTERVAL BETWEEN ONSET AND DEATH 2 hours 24 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Cirrhosis of liver				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) —			
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ 19 57				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	
20f. (City or town) —				20g. (County) —		20h. (State) —	
21. I certify that I attended the deceased from June 25, 1956 to Feb 2, 1957 that I last saw the deceased alive on Jan 28, 1957 , and that death occurred at 1:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE George L Ball				ADDRESS (Street, city or town, state) 7835 Eastern Ave Silver Spring Md			
PHYSICIAN'S NAME (Type) George L Ball				DATE SIGNED —			
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 2-2-1957		22c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery		22d. LOCATION (City, town, or county) (State) North Arlington New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co				ADDRESS 1400 Chapin St		24. REC'D BY REGISTRAR 7/5	
24b. REGISTRAR'S SIGNATURE Frances Potter							

RECEIVED

FEB 11 1957

BUREAU V. S.

1922

CERTIFICATE OF DEATH

Reg. Dist. No.

273

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tru Ma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 4th</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanitarium & Hosp.</u>		e. STREET ADDRESS <u>1500 Massachusetts Ave N.W.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Carrie Belle Kinter</u>		4. DATE OF DEATH Month Day Year <u>February 17 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 11, 1870</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel S. Jack</u>		14. MOTHER'S MAIDEN NAME <u>Hannah Truby</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebro vascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis cerebri</u> DUE TO (c) <u>old age.</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>0 hours</u> <u>many years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/6</u> , 19 <u>57</u> , to <u>2/17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/17</u> , 19 <u>57</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. Philip Bloomer</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>594 16th St. N.W. Wash. D.C. 2-17-57</u>	
PHYSICIAN'S NAME (Type) <u>Philip Bloomer M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>2/18/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. W. Chambers Co</u>		ADDRESS <u>1400 Chapin St. N.W.</u>	
24a. REC'D BY REGISTRAR <u>19 1957</u>		24b. REGISTRAR'S SIGNATURE <u>J. Nelson Soder</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 3 1957

RECEIVED

2001

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Germanstown</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Germanstown</i>			
c. LENGTH OF STAY IN 1b <i>53</i>				d. STREET ADDRESS <i>1</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Mary</i> First <i>Ethel</i> Middle <i>Kirby</i> Last				4. DATE OF DEATH <i>February - 23 - 1957</i> Month Day Year			
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Feb 1 - 1886</i>	
9. AGE (In years last birthday) <i>71</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS		11. BIRTHPLACE (State or foreign country) <i>Frederick Co., Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>house-keeping at home</i>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <i>Marion Eugene Hood</i>				14. MOTHER'S MAIDEN NAME <i>Emma Frances Crawford</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>no</i>			
17. INFORMANT <i>Donald Eugene Kirby</i> Address <i>Germanstown, Md.</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic heart failure</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i> <i>4 d. 1. 0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>mitral insufficiency</i> <i>35 years</i> DUE TO (c) <i>Arthritis</i> <i>30-35 years</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>March - 24 - 1914</i> , to <i>Feb - 23 - 1957</i> , that I last saw the deceased alive on <i>Feb - 23 - 1957</i> , and that death occurred at <i>4:00 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>William C. Miller</i> M.D. <i>7 Brooke Ave., Gaithersburg, Md.</i> ADDRESS (Street, city or town, state) DATE SIGNED <i>2/23/57</i>							
PHYSICIAN'S NAME (Type) <i>WILLIAM C. MILLER</i> <i>GAITHERSBURG, MD.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2-26-57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Wm. Christ</i>		22d. LOCATION (City, town, or county) (State) <i>Frederick Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ernest L. Gaither</i> ADDRESS <i>Gaithersburg, Md.</i>				24. REC'D BY REGISTRAR <i>25-57</i>		24b. REGISTRAR'S SIGNATURE <i>Archie G. Cooke</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO PUBLIC HEALTH DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 27 1957

RECEIVED

2002

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>21 hrs. x2 Gaithersburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. STREET ADDRESS <u>19 Brooks Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Albert Gwynn Kirkman</u>		4. DATE OF DEATH <u>Feb. 1 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/30/06</u>
9. AGE (In years last birthday) <u>50</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>	
11. BIRTHPLACE (State or foreign country) <u>Gaithersburg, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Albert A. Kirkman</u>		14. MOTHER'S MAIDEN NAME <u>Ellie Hunter Gavin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>2nd war</u>		16. SOCIAL SECURITY NO. <u>2nd war</u>	
17. INFORMANT <u>Salie T. Kirkman, Gaithersburg, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ACUTE LEFT VENTRICULAR FAILURE</u> DUE TO (c) <u>CORONARY ARTERY DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 MINUTES</u> <u>24 HOURS</u> <u>FIVE YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>DEC 27 1956</u> to <u>FEB 1 1957</u> , that I last saw the deceased alive on <u>FEB 1 1957</u> , and that death occurred at <u>10:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gordon Rosenberg</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>26 N. Summit Ave. Gaithersburg, Md. Feb 1957</u>	
PHYSICIAN'S NAME (Type) <u>Gordon Rosenberg</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-4-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Frost Oak</u>	22d. LOCATION (City, town, or county) (State) <u>Gaithersburg Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Emmett C. Galtner, Gaithersburg, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 2-4-57</u>	
		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

RECEIVED
FEB 7 1957
BUREAU V. S.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02012

2003 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>4 hours</u>				d. STREET ADDRESS <u>12304 Charles Road</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>L</u> Last <u>Koyce</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 4 1903</u>	
9. AGE (In years lost birthday) <u>53</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Rhode Island U.S.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Patrick J. Dolan</u>				14. MOTHER'S MAIDEN NAME <u>Lillian Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u> </u> (If yes, give war or date of service) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Arthur T. Koyce</u>				Address <u>12304 Charles Rd. Silver Spring Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal Hemorrhage</u> 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Esophageal varices</u> DUE TO (c) <u>Hepatic cirrhosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>2-10</u> , 19 <u>57</u> , to <u>2-11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-11</u> , 19 <u>57</u> , and that death occurred at <u>1:20 A.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>4714 Highland Ave Bethesda, Md.</u> DATE SIGNED <u>2/11/57</u>							
ACTUAL SIGNATURE <u>Alfred S. Norton</u>				M.D. <u>4714 Highland Ave Bethesda, Md.</u>			
PHYSICIAN'S NAME (Type) <u>ALFRED S. NORTON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warren E. Humphrey</u>				ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	
				DATE <u>2-12-57</u>			

RECEIVED V. S.

1957

DEPT. OF JUSTICE

02013
217

2004

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brouke Grove Chronic Hosp.</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jessie Davis Ladson</u>		4. DATE OF DEATH Month Day Year <u>Feb. 5 1957</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 19, 1887</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Fredonia N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry E. Davis</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Emily Ryman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Dr. T. A. Ladson, son - Olney Md.</u>	
17. INFORMANT <u>Dr. T. A. Ladson, son - Olney Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO <u>42001</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY THROMBOSIS</u> DUE TO <u>MYOCARDIAL INFARCTION</u> (c) <u>MYOCARDIAL INFARCTION</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 hr</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 5</u> , 19 <u>57</u> , to <u>Feb 5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 5</u> , 19 <u>57</u> , and that death occurred at <u>6:40 A.M.</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>OLNEY MD.</u>		DATE SIGNED <u>Feb 5 1957</u>	
ACTUAL SIGNATURE <u>John P. Ziegler</u> M.D.		DATE SIGNED <u>Feb 5 1957</u>	
PHYSICIAN'S NAME (Type) <u>John P. Ziegler</u>		DATE SIGNED <u>Feb 5 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	22b. DATE THEREOF <u>Feb 5 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN</u>	22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray W. Barber</u> ADDRESS <u>Laytonville, Md.</u>		24a. REC'D BY REGISTRAR <u>Feb 8 1957</u>	24b. REGISTRAR'S SIGNATURE <u>John P. Ziegler</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Harry E. Davis -
Horse wife
F White

Brook Grove Chronic Hosp -
Cliff
Went in at 3 1/2 hrs

Jessie
Jesse Madison
Mar 18, 1887
Frederic W. St.
Eliza Emily
Dr. J. C. Madison, Gov. - 1904

Cliff
Madison
Went in at 3 1/2 hrs

Gov
Feb 2, 1904 V. S.

RECEIVED

Form 20 Film 211 3-11-57 ans

2005

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE NEW JERSEY b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WEST ENGLEWOOD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MAPLE LANE SANITARIUM		d. STREET ADDRESS 30 GARDEN STREET	
3. NAME OF DECEASED (Type or print) First BERTHA Middle ALMA Last LAMP		4. DATE OF DEATH Month FEB. Day 24 Year 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/1/73
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Law clerk		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs 83
11. BIRTHPLACE (State or foreign country) BROOKLYN, NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY LAMP		14. MOTHER'S MAIDEN NAME KATHERINE WIESE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. John D. Snyder, 3805 Calvert Place Kensington, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDITIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) FRACTURE OF RIGHT FEMUR DUE TO (c) FEMORAL THROMBOSIS (RIGHT)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4 SENILITY		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) She arose from bed at night and while walking around her room fell to the floor	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 10:45 p. m. Feb 5 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from FEB 2 , 19 57 , to FEB 24 , 19 57 , that I last saw the deceased alive on FEB 24 , 19 57 , and that death occurred at 4:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry M. Lowden M.D. 5206 NORWAY DR. 2/4/57		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) HENRY M. LOWDEN		CHEVY CHASE, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 2/25/57	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) TEANECK, NEW JERSEY
23. FUNERAL DIRECTOR'S SIGNATURE Laurel & Humphrey ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 2/8	24b. REGISTRAR'S SIGNATURE

1. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 4 1957

BUREAU V. S.

1923

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN. & HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
3. NAME OF DECEASED (Type or print) First Middle Last STEWART DeWARREN LASHLEY		4. DATE OF DEATH Month Day Year FEB. 4 19 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1899
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fiscal Auditor - General Accounting Office		10b. KIND OF BUSINESS OR INDUSTRY Bedford County, Pa.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Wimbert Lashley		14. MOTHER'S MAIDEN NAME Mary Blanche Imes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 577-44-8168	
17. INFORMANT Mrs. Mary S. Lashley, 7 Sunnyside Road		Address Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple myeloma DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 4, 1940 to Feb. 4, 1957 , that I last saw the deceased alive on Feb. 4, 1957 , and that death occurred at 12:50 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. B. Wardrop M.D.		ADDRESS (Street, city or town, state) 837 Bonifant St., Silver Spring, Md.	
PHYSICIAN'S NAME (Type) WILLIAM B. WARDROP, M.D.		DATE SIGNED 2/4/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/7/57	
22c. NAME OF CEMETERY OR CREMATORY GEO. WASH. MEM. CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR 1957		24b. REGISTRAR'S SIGNATURE John L. Ladd	

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be obtained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/55

RECEIVED

FEB 7 1957

BUREAU V. S.

1924

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8626 FLOWER AVENUE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK d. STREET ADDRESS 8626 FLOWER AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle TRUSLOW Last LEPS		4. DATE OF DEATH Month FEB. Day 16 Year 19 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/1/09
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hair stylist		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) KEYSER, WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LOUIS S. LEPS		14. MOTHER'S MAIDEN NAME NANNIE E. LONG	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 578-01-1930	
17. INFORMANT Mrs. Lillian C. Leps, 8626 Flower Ave. Takoma Park, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure DUE TO Acute Coronary Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Arteriosclerosis (c) Coronary Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 hr. INTERVAL BETWEEN ONSET AND DEATH 2 hr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 10 , 19 57 , to Feb - 16 , 19 57 , that I last saw the deceased alive on Feb 4 , 19 57 , and that death occurred at 12:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3066 - Canal - 44 - Unit 1st DATE SIGNED ACTUAL SIGNATURE E. Stuart Lyddane M.D. PHYSICIAN'S NAME (Type) E. STUART LYDDANE			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/19/57	
22c. NAME OF CEMETERY OR CREMATORY NATIONAL M.M. PARK CEMETERY		22d. LOCATION (City, town, or county) (State) FALLS CHURCH, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Walter B. Hunsbrey ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR 2/20/57 24b. REGISTRAR'S SIGNATURE William Dodd	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 27 1937

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2906

CERTIFICATE OF DEATH

02017

Reg. Dist. No. 212

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson--Rural				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson--Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Guy Middle V Last Lewis				4. DATE OF DEATH Month Feb Day 4 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2-1898	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm owner & Grower of peaches				10b. KIND OF BUSINESS OR INDUSTRY Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Joseph Hooker Lewis				14. MOTHER'S MAIDEN NAME Virginia Kolbaugh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service) 1917-1918		16. SOCIAL SECURITY NO. 219-07-9100		17. INFORMANT Guy V. Lewis, Jr. Dickerson Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct Posterior DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Arteriosclerosis with insufficiency DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 36 days 36 days 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 3 January, 1957 to 4 February 1957 , that I last saw the deceased alive on 4 February 1957 , and that death occurred at 12:25 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Gordon M. Smith				ADDRESS (Street, city or town, state) BARNESVILLE DATE 5 Feb 57			
PHYSICIAN'S NAME (Type) GORDON M. SMITH							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/7/57		22c. NAME OF CEMETERY OR CREMATORY Mt Olivet		22d. LOCATION (City, town, or county) (State) Frederick Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William B. Hilton, Barnesville Md				24a. REC'D BY REGISTRAR Charles W. Elgin		24b. REGISTRAR'S SIGNATURE Charles W. Elgin	

BUREAU V. S.

FEB 11 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2007

CERTIFICATE OF DEATH

02018

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrett Park Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrett Park Kensington, Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5009 Cushing Dr</u>		d. STREET ADDRESS <u>5009 Cushing Dr</u>	
3. NAME OF DECEASED (Type or print) <u>Victoria</u> First <u>Anna</u> Middle <u>LITAK</u> Last		4. DATE OF DEATH <u>Feb. 12,</u> Month <u>12,</u> Day <u>19</u> Year <u>57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 28 1892</u>
9. AGE (in years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR: Months <u>8</u> Days <u>14</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>062-24-7045</u>	
17. INFORMANT <u>Raymond Ksiazek</u> Address <u>5009 Cushing Dr</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion - Aorta -</u> DUE TO <u>Anterior Occlusion; Dilated - Enlarged -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Factorized -</u> DUE TO <u>gyc</u> (b) <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 Hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1/19/57</u> , 19 <u>57</u> , to <u>2/12/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/12/57</u> , 19 <u>57</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Samuel Allen</u> M.D.		ADDRESS (Street, city or town, state) <u>Kensington, Md</u> DATE SIGNED <u>2/12/57</u>	
PHYSICIAN'S NAME (Type) <u>SAMUEL ALLEN</u>		<u>KENSINGTON, MD.</u> <u>2-12-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-15-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Michaels Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Lackawanna County, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u> ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>2-15-57</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>

W. H. K.

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02019

2008

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>			c. LENGTH OF STAY IN 1b <u>1 Day</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>U.S. Naval Hospital, Bethesda, Maryland</u>			e. STREET ADDRESS <u>5921 Loch Court</u>		
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ah (nmn) LOY</u>			4. DATE DATE Month Day Year <u>February 25 19 57</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Chinese</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>8 August 1870</u>	9. AGE (In years last birthday) <u>86</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Navy</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy (Retired)</u>		11. BIRTHPLACE (State or foreign country) <u>China</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> WW-I		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mrs. Norena R. Kai (Foster-Daughter) (Same As #2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, multi-lobar</u> <u>490x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>25 Feb.</u> , 19 <u>57</u> , to <u>25 Feb.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>25 Feb.</u> , 19 <u>57</u> , and that death occurred at <u>10:17 P.M.</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>T. S. Dunn Jr</u>		M.D. <u>U.S. Naval Hospital, Bethesda, Md. 2-26-57</u>			
PHYSICIAN'S NAME (Type) <u>T. S. DUNN, JR, LT, MC, USN</u>		<u>U.S. Naval Hospital, Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1 March 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Arlington, Va.</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>			ADDRESS <u>Washington, D.C.</u> <u>Lee Funeral Home, 4th & Mass. Ave., N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>2-25-57</u>
24b. REGISTRAR'S SIGNATURE <u>Mary E. Carrelly</u>					

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1

TO BE COMPLETED BY THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate has been signed by the attending physician and completely filled out. It should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2009

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster 06-27-</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Asbury Methodist Home</u>				d. STREET ADDRESS <u>164 West Main St.</u>			
3. NAME OF DECEASED (Type or print) First <u>FLORENCE</u> Middle <u>MALEHORN</u> Last <u>MALEHORN</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 23, 1873</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>saleslady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>dry goods store</u>		11. BIRTHPLACE (State or foreign country) <u>Westminster, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Andrew Jackson Malehorn</u>			
14. MOTHER'S MAIDEN NAME <u>Ellen B. Koontz</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or date of service)			
16. SOCIAL SECURITY NO. <u>none</u>				17. INFORMANT <u>Methodist Home Records-</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-14</u> , 19 <u>56</u> , to <u>2-20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-20</u> , 19 <u>57</u> , and that death occurred at <u>9:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sarah E. Glover</u> M.D.				ADDRESS (Street, city or town, state) <u>4208 ANTHONY ST. Kensington, Md.</u> DATE SIGNED <u>2-20-57</u>			
PHYSICIAN'S NAME (Type) <u>SARAH E. GLOVER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-22-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery, Westminster, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw. Dantley Gaithersburg, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>2-21-57</u>		24b. REGISTRAR'S SIGNATURE <u>Abigail L. Cooke</u>	

RECEIVED
FEB 25 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02021

2010

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6131 Nevada Avenue</u>				d. STREET ADDRESS <u>1 6131 Nevada Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>HOWARD</u> Last <u>MARK</u>				4. DATE OF DEATH Month <u>FEB</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 5, 1869</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pullman Conductor (Retired) Railroad</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Franklin Marr</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Sweeney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>SISTER - Lulu Eno-Chevy Chase, Md.</u>				Address <u>6131 Nevada Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA STOMACH</u> <u>101X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY ARTERY DISEASE</u> (c) <u>CHRONIC PULMONARY FIBROSIS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 MOS</u> <u>10 YRS</u> <u>20 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>DEC 21, 1942</u> to <u>FEB 16, 1957</u> , that I last saw the deceased alive on <u>FEB 15, 1957</u> , and that death occurred at <u>3:30 A.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Robert G. Taylor</u> M.D. <u>Washington Clinic</u>							
PHYSICIAN'S NAME (Type) <u>ROBERT G. TAYLOR</u> <u>Washington 15, D.C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/18/57</u>		<u>Cedar Hill Cemetery</u>		<u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>The S.H. Hines Co. 2901 14th St. N.W. Washington 9, D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 18 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>	

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RECEIVED

2011 **CERTIFICATE OF DEATH**

Reg. Dist. No. 7.4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY MONTGOMERY		MARYLAND		STATE MARYLAND		COUNTY MONTGOMERY	
CITY (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		LENGTH OF STAY (In this place) 1 week		CITY (If outside corporate limits, write RURAL and give nearest town) KENSINGTON			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Le DEAU NURSING HOME				STREET ADDRESS 10,613 CONCORD STREET		(If rural give location)	
3. NAME OF DECEASED (Type or Print) AVONDALE PURDUM MATTHEWS				4. DATE OF DEATH (Month) FEB (Day) 2 (Year) 1957			
5. SEX Female		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH 9/14/76	
				9. AGE last birthday 80 yrs.		IF UNDER 1 YEAR Months Days	
						IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) CLARKSBURG, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME CHARLES THOMAS PURDUM				14. MOTHER'S MAIDEN NAME HARRIET HOBBS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS Mr. William F. Matthews 10,613 Concord St., Kensington, Md.	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) HEART FAILURE, ACUTE				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) MYELOTHISIC ANEMIA				4 mo.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) THROMBOCYTOPENIA							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from NOV 11, 1956, to FEB 2, 1957, that I last saw the deceased alive on FEB 2, 1957, and that death occurred at 9:45 P.M. from the causes and on the date stated above.							
SIGNATURE Robert J. Philodorean, M.D.				DATE SIGNED M.D. 10/6/57			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				DATE THEREOF 2/4/57		NAME OF CEMETERY OR CREMATORY CEDAR GROVE BAPTIST CHURCH CEMETERY	
24. REC'D BY REGISTRAR				REGISTRAR'S SIGNATURE Frances Toller		25. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey	
DATE 2-6-57				ADDRESS (Street, city, town, state) 10,613 Concord St., Kensington, Md.		ADDRESS SILVER SPRING, MD.	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 12 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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FEB 11 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2012

CERTIFICATE OF DEATH

02023

Reg. Dist. No.

2 7

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>6 to 4th</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Sanitarium</u>				d. STREET ADDRESS <u>610 Princeton Pl. NW</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Fredrick</u> Middle <u>G.</u> Last <u>Meyer</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/22/79</u>	
9. AGE (In years lost birthday) <u>77</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Purchaser</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Charles Meyer</u>			
14. MOTHER'S MAIDEN NAME <u>Frieda Wolfe</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO				17. INFORMANT <u>Mrs. Anna Kunth</u> Address <u>834 East Ave, Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>34 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>o. 11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>54</u> , to <u>Feb 22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 22</u> , 19 <u>57</u> , and that death occurred at <u>5:55 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>P. K. Ray, M.D.</u>				ADDRESS (Street, city or town, state)			
PHYSICIAN'S NAME (Type) <u>S. L. TABB, M.D.</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/25/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Church Cem</u>		22d. LOCATION (City, town, or county) (State) <u>West Lake</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. F. Christman & Son</u>				24a. REC'D BY REGISTRAR <u>2-24-57</u>		24b. REGISTRAR'S SIGNATURE	

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BUREAU V. S.

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2013 CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN lb 13 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montg. Co. Gen.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Griffith Last Mobley		4. DATE OF DEATH Month Feb. Day 24 Year 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/9/1867
9. AGE (In years last birthday) yrs. 89		IF UNDER 1 YEAR Months 10 Days 15 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David Griffith		14. MOTHER'S MAIDEN NAME Anna S. Taylor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hosp. Records		Address Olney, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Vascular Accident DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 2 days 11 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Feb 8, 1957 , 19 Feb 24 , 19 57 , that I last saw the deceased alive on Feb 24 , 19 57 , and that death occurred at 10:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Gaithersburg, Md. DATE SIGNED 2-24-57			
ACTUAL SIGNATURE T. J. Brochert M.D.		PHYSICIAN'S NAME (Type) T. J. Brochert Gaithersburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/26/57	22c. NAME OF CEMETERY OR CREMATORY Rockville Union
22d. LOCATION (City, town, or county) Rockville		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR 2-26-57		24b. REGISTRAR'S SIGNATURE Septulius Lawbr	

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MAR 1 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22 Filmroll 2-15-57 et

02025

CERTIFICATE OF DEATH

Reg. Dist. No. 215

2014

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 3 mos. 9 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Wesley Carr MONTAGUE				4. DATE OF DEATH Month February Day 14 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 27 Jan. 1898	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Promoter				10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME James Wesley Montague				14. MOTHER'S MAIDEN NAME Luola Flemming			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW-I				16. SOCIAL SECURITY NO. 578 24 6269		17. INFORMANT (Sister) Mrs. Ida M. Atkins	
				Address Richmond, Va. 411 N. Allen Ave.,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 148X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) METASTATIC CARCINOMA DUE TO (c) SQUAMOUS CELL CARCINOMA OF PHARYNX							INTERVAL BETWEEN ONSET AND DEATH 2 MOS 2 YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 Month, Day, Year p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 5 Nov. 19 56 to 14 Feb. 19 57 , that I last saw the deceased alive on 14 Feb. 19 57 , and that death occurred at 1:55 M, from the causes and on the date stated above ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 2-14-57							
ACTUAL SIGNATURE G. W. Taylor M.D. U.S. Naval Hospital, Bethesda, Md.							
PHYSICIAN'S NAME (Type) G. W. TAYLOR, CDR, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-19-57		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Chambers, 3072 M St., N.W. Washington, D.C.				24. REC'D BY REGISTRAR 2-14-57			

AND V. S.

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1925 CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium + Hosp.</i>				d. STREET ADDRESS <i>805 New York Ave</i>			
3. NAME OF DECEASED (Type or print) First <i>Juanita</i> Middle <i>Celestia</i> Last <i>Moorhead</i>				4. DATE OF DEATH Month <i>2</i> Day <i>23</i> Year <i>1957</i>			
5. SEX <i>fe</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-14-97</i>	9. AGE (In years last birthday) <i>59</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Ohio</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Robinson</i>				14. MOTHER'S MAIDEN NAME <i>Cora Naylor</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>None</i>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Hospital Record & Husband</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Terminal carcinoma</i> DUE TO (b) <i>Primary carcinoma of stomach</i> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <i>2/15</i> 1957, to <i>2/23</i> 1957, that I last saw the deceased alive on <i>2/23</i> 1957, and that death occurred at <i>1:37</i> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Eino Magi</i> M.D.				ADDRESS (Street, city or town, state) <i>8401 University Lane, Silver Spring, Maryland</i>			
PHYSICIAN'S NAME (Type) <i>EINO MAGI</i>				DATE SIGNED <i>2/23/57</i>			
22a. BURIAL, CREMATION, C. REMOVAL (Specify) <i>REMOVAL</i>		22b. DATE THEREOF <i>FEB 26, 1957</i>		22c. NAME OF CEMETERY OR CREMATORY <i>CEDARHILL CREMATORY</i>		22d. LOCATION (City, town, or county) <i>PAGE FRT PR GEO CO</i> (State) <i>MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. ...</i> ADDRESS <i>2510 ...</i>				24. REC'D BY REGISTRAR <i>FEB 25 1957</i> 25. REGISTRAR'S SIGNATURE <i>William ...</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 27 1957

BUREAU V. S.

2015

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH o COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o STATE <u>Md</u> b COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10005 Tenbrook Drive</u>		d. STREET ADDRESS <u>19605 Dallas Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Virginia Boxwell Moulden</u>		4. DATE OF DEATH <u>Feb 12 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 10 - 1896</u>
9. AGE (In years last birthday) <u>60</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Manchester, Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edmond Glaize</u>		14. MOTHER'S MAIDEN NAME <u>Emma Boxwell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Percy Nelson Moulden</u>		Address <u>9605 Dallas Ave Silver Spring, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO <u>Gen Arteriosclerosis & Hypertension</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <u>Cerebral Hem. - left Hemiplegia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs</u> <u>Jan 1943</u> <u>DEC 14 1956</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/9/1943</u> to <u>2/12/1957</u> , that I last saw the deceased alive on <u>2/12/1957</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard T. Morse</u> M.D.		ADDRESS (Street, city or town, state) <u>2030 Carroll Ave</u>	
PHYSICIAN'S NAME (Type) <u>Howard T. Morse</u>		DATE SIGNED <u>2/12/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/13/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner S. Humphrey</u> ADDRESS <u>Silver Spring, Md</u>		24a. REC'D BY REGISTRAR <u>Francis J. Jell</u> 24b. REGISTRAR'S SIGNATURE <u>Francis J. Jell</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 19 1957

RECEIVED

2016 CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Harroll		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney			c. LENGTH OF STAY IN 1b 18 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Clifton Middle Asbury Last Mullinix			4. DATE OF DEATH Month February Day 14 Year 19 57		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/21/78 78 yrs.		9. AGE (in years last birthday) IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner Lumber Company		10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME Frank Mullinix			14. MOTHER'S MAIDEN NAME Rachel Poole		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-12-2003		17. INFORMANT Hospital Record	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarct DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) acute coronary thrombosis DUE TO (c) coronary atherosclerosis					INTERVAL BETWEEN ONSET AND DEATH 3 week 11 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) acute pulmonary infarct					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 27, 1957 to Feb 14, 1957 , that I last saw the deceased alive on Feb 14, 1957 , and that death occurred at 11:30 AM , from the causes and on the date stated above.					
ACTUAL SIGNATURE G. F. Meadors		M.D. Damascus, Md.		ADDRESS (Street, city or town, state) Damascus, Md. DATE SIGNED 2/14/57	
PHYSICIAN'S NAME (Type) G. F. Meadors, M. D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-16-1957		22c. NAME OF CEMETERY OR CREMATOR Montgomery Chapel	
22d. LOCATION (City, town, or county) (State) Montgomery Co., Md.					
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Md.		24a. REC'D BY REGISTRAR Feb 18 1957	
		24b. REGISTRAR'S SIGNATURE Gertrude Lawley			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 1937

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film 211 2-18-57 et

2017

CERTIFICATE OF DEATH

02029

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE C. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 14 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 3307 Stephenson Pl. NW			
3. NAME OF DECEASED (Type or print) First Sophie Middle Josephine Last Nolda				4. DATE OF DEATH Month February Day 18 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 6, 1875	9. AGE (In years last birthday) yrs. 81	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Austria-Hungary		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Mathias Dworack				14. MOTHER'S MAIDEN NAME Anna-Janecak			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT son - same		Address Henry Nolda	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 90110 Confluent Bronchopneumonia - upper lobe DUE TO (b) Cerebral Concussion DUE TO (c) Fall at home						INTERVAL BETWEEN ONSET AND DEATH 4 days 14 days 14 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Advanced Arteriosclerosis						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell over bathtub.				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 3 p. m. 2/4 1957			20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		
			20f. (City or town) Washington, D.C.		(County) (State)		
21. I certify that I attended the deceased from 7/1 , 19 55 , to 2/18 , 19 57 , that I last saw the deceased alive on 2/18 , 19 57 , and that death occurred at 8:57 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Seymour Greenbaum			ADDRESS (Street, city or town, state) DATE SIGNED 9300 EWING DR. BETHESDA, M.D. 2/18/57				
PHYSICIAN'S NAME (Type) SEYMOUR GREENBAUM, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 2/21/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.			ADDRESS Washington, D.C.		24a. REC'D BY REGISTRAR 20-57		
					24b. REGISTRAR'S SIGNATURE Bessie M. Thompson		

RECEIVED

FEB 25 1957

BUREAU V. S.

2018 CERTIFICATE OF DEATH

Reg. Dist. No.

0203014

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>MARYLAND</u> c. COUNTY <u>D. C. COUNTY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>giving</u>				d. STREET ADDRESS <u>1805 THURMAN AVE.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>RAYMOND</u> Middle <u>ALLEN</u> Last <u>OSBORN</u>				4. DATE OF DEATH Month <u>11</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 9, 1893</u>		9. AGE (In years last birthday) <u>63</u> yrs	IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>CHANDLER, MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>—</u>		
13. FATHER'S NAME <u>ALEXANDER LINDA ISAACSON</u>				14. MOTHER'S MAIDEN NAME <u>THOMAS VIRGINIA SMITH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>N</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Dr. Raymond A. OSBORN</u> Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u>							<u>3 1/2 months</u>
420.1 DUE TO (b) <u>CARDIAC HEART DISEASE</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 3, 1953</u> , to <u>February 23, 1957</u> , that I last saw the deceased alive on <u>Feb 23, 1957</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Michael J. McInerney</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>MICHAEL J. McINERNEY</u> <u>1100 CONN. ST. NW</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>2-25-57</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>mt. Olivet Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Haulon</u> ADDRESS <u>3831- 24th NW Wash D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>11-25-57</u>		24b. REGISTRAR'S SIGNATURE <u>James Patter</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FEB 25 1957

BUREAU Y. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02031

2019

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Henry			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 31 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 82X-3 Spencer				d. STREET ADDRESS Route # 1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center National Institutes of Health, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Sanders Middle Andrew Last Palmer			4. DATE OF DEATH Month February Day 28 Year 1957				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 September 1888		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY Self-employed farming		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William P. Palmer				14. MOTHER'S MAIDEN NAME Elizabeth Lawson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Not available		17. INFORMANT The Medical Record, Clinical Center National Institutes of Health, Bethesda 14, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO PNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MYCOSIS FUNGOIDES DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 21 days 21 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cystitis, pyelonephritis, emphysema							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 28, 1957 , to February 20, 1957 , that I last saw the deceased alive on February 20, 1957 , and that death occurred at 4:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Samuel Charache M.D.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Md.			
PHYSICIAN'S NAME (Type) Samuel Charache, M. D.				DATE SIGNED 3/1/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit		22b. DATE THEREOF 3/2/1957		22c. NAME OF CEMETERY OR CREMATORY Stuart		22d. LOCATION (City, town, or county) (State) Stuart Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey,				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 3-2-57	
				24b. REGISTRAR'S SIGNATURE Bennie M. Thompson			

BUREAU V. S.

MAR 2 1904

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02032

2020

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			d. STREET ADDRESS 423 Massachusetts Avenue		
3. NAME OF DECEASED (Type or print) First Annie Middle Tibbs Last Phillips			4. DATE OF DEATH Month February Day 19 Year 19 57		
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 28, 1906		9. AGE (In years last birthday) 50 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) District of Columbia
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Frank Tibbs		
14. MOTHER'S MAIDEN NAME Unascertainable			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO Unknown			17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARRHYTHMIA DUE TO myocardial irritability Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic pyelonephritis (c) Hypertension					INTERVAL BETWEEN ONSET AND DEATH minutes months years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary congestion, edema and pleural effusion					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NONE		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II (item 18).) NONE			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. NONE 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from January 3, 1957 , to February 19, 1957 , that I last saw the deceased alive on February 19, 1957 , and that death occurred at 9:25 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE William J. Pieper M.D.		ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 2-20-57	
PHYSICIAN'S NAME (Type) William J. Pieper, M. D.		National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/25/57	22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or County) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE R. N. Horton Co		ADDRESS 1332 U. S. St. N.E.		24a. REC'D BY REGISTRAR FEB 25 1957	24b. REGISTRAR'S SIGNATURE Bessie Thompson

6 2

BUREAU V. S.

FEB 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02033
 Reg. Dist. No. **223**

1926

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakewood Park</u>				c. LENGTH OF STAY IN 1b <u>4 wks</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash Sen. & Hosp</u>				d. STREET ADDRESS <u>R.F.D. # 2</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sharon Ella Pickens</u>				4. DATE OF DEATH Month Day Year <u>2-8-1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-21-48</u>		9. AGE (In years last birthday) <u>9</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>DC</u>	
13. FATHER'S NAME <u>Hayward F Pickens</u>				14. MOTHER'S MAIDEN NAME <u>Ethel Allen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Hosp records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia & pulmonary edema</u> <u>916.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>3rd degree burns (60% of body)</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Clothes caught on fire from trash fire at home</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>12:45</u> p.m. <u>1-12</u> 1957				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
				20f. (City or town) <u>Silver Spring</u> (County) <u>Montg</u> (State) <u>md</u>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/12/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Werner E. Timm</u> ADDRESS <u>8434 GA AVE S.S. MD</u>							

FEB 12 1957 Werner E. Timm

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

S A CETERA

19

LEAVE

2021 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4612 Montgomery Avenue				d. STREET ADDRESS 4612 Montgomery Avenue			
3. NAME OF DECEASED (Type or print) First Arthur Middle C Last POOLE				4. DATE OF DEATH Month February Day 18 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/12/1880		9. AGE (In years last birthday) 76 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months 11 Days 6 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. D.C. Fire Dept.			10b. KIND OF BUSINESS OR INDUSTRY Fireman		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Lorenza P. Poole				14. MOTHER'S MAIDEN NAME Sally Sarah M. Devine			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 577-01-8908		17. INFORMANT Ida C. Poole, 4612 Montg. Ave. Beth. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Left Ventricular Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Heart Disease DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 16, 1957 , to Feb 18, 1957 , that I last saw the deceased alive on Feb 18, 1957 , and that death occurred at 11:55 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4709 Montgomery Lane, Bethesda, Md. DATE SIGNED 							
ACTUAL SIGNATURE Paul D. Cantor M.D.							
PHYSICIAN'S NAME (Type) Paul D. Cantor, M.D.				4709 Montgomery Lane, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/18/57	22c. NAME OF CEMETERY OR CREMATORY Rockville Union		22d. LOCATION (City, town, or county) (State) Rockville Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY, Bethesda, Maryland				24a. REC'D BY REGISTRAR 2-20-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
FEB 25 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2022

CERTIFICATE OF DEATH

02035

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>9529 Erving Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Agnes</u> Last <u>Rae</u>		4. DATE OF DEATH <u>Feb. 11 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 12 1867</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>11</u> Days <u>19</u> Hours <u>57</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Rocaft</u>		14. MOTHER'S MAIDEN NAME <u>Helena Mcnea</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Helen Clifford</u>		Address <u>9529 Erving Dr Bethesda Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal obstruction</u> DUE TO <u>114X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>metastatic cancer, widespread</u> DUE TO (c) <u>Sarcoma, uterus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1+ yrs</u> <u>10+ yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>diabetes, arteriosclerotic heart disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 19 1957</u> to <u>Feb 10 1957</u> , that I last saw the deceased alive on <u>2/10 1957</u> , and that death occurred at <u>3:35 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles J. Savarese</u> M.D.		ADDRESS (Street, city or town, state) <u>14861 Battery Lane</u>	
PHYSICIAN'S NAME (Type) <u>CHARLES J. SAVARESE, J.</u>		DATE SIGNED <u>2/11/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/14/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Wash DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.A. Hunterman & Son</u>		24a. REC'D BY REGISTRAR <u>2-14-57</u>	
ADDRESS <u>5732 Ka Ave NW</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

REAR V. 8

1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2023

CERTIFICATE OF DEATH

Reg. Dist. No.

02036
276

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Vol-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last Daniel Abner Ramage				4. DATE OF DEATH Month Day Year February 14, 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 23, 1886		9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Engineering		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Ramage				14. MOTHER'S MAIDEN NAME Sarah Heatherly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 194-01-2718		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Divertericuli and peritonitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Abscess of prostate DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, Heart disease, Cirrhosis of the liver, Rheumatoid arthritis							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from September 22, 1954 to February 14, 1957 , that I last saw the deceased alive on February 14, 1957 , and that death occurred at 11:15 AM , from the causes and on the date stated above							
ACTUAL SIGNATURE James R. Stabenau M.D.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) James R. Stabenau, M. D.				DATE SIGNED 4/19/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/18/57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		22d. LOCATION (City, town, or county) (State) Brooklyn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes 130 E. Fort Ave.				24a. REC'D BY REGISTRAR Feb 19 1957 24b. REGISTRAR'S SIGNATURE Bessie Thompson			

BUREAU V. S.

FEB 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2024

CERTIFICATE OF DEATH

Reg. Dist. No.

02037

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 98 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 1033 Quebec Terrace, Apt. 3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Walter Last Robertson		4. DATE OF DEATH Month February Day 5 Year 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 10, 1907
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months 49 Days 19 Hours 57 Min.	IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photographer		10b. KIND OF BUSINESS OR INDUSTRY Photography	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Robertson		14. MOTHER'S MAIDEN NAME Georgia Knott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 579-03-2620	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Multiple myeloma DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p. Month, Day, Year p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from October 30, 1957 to February 5, 1957 , that I last saw the deceased alive on February 5, 1957 , and that death occurred at 9:35 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James R. Stabenau M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) James R. Stabenau, M. D.		DATE SIGNED 2/5/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-8-57	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) (State) Suitland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Lee's Sons Co. ADDRESS Washington,		24a. REC'D BY REGISTRAR FEB 7 1957	24b. REGISTRAR'S SIGNATURE Bessie Thompson

RECEIVED

FEB 7 1957

BUREAU V. S.

2025 CERTIFICATE OF DEATH

Reg. Dist. No. 020286

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 14, Maryland</u>		c. LENGTH OF STAY IN 1b <u>143 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Orlando 4</u>	
f. STREET ADDRESS <u>1912 Garvin Street</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sidney</u> Middle <u>Benard</u> Last <u>Schaeffer</u>		4. DATE OF DEATH Month <u>February</u> Day <u>10</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 15, 1939</u>
9. AGE (In years last birthday) <u>17</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>	
11. BIRTHPLACE (State or foreign country) <u>Florida</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Earl Schaeffer</u>		14. MOTHER'S MAIDEN NAME <u>Mary McCraig</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Not available</u>	
17. INFORMANT <u>The Medical Record</u>		18. ADDRESS <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic glomerulonephritis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. f. l. p. m. _____ Month, Day, Year _____ 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>September 20, 1956</u> to <u>February 10, 1957</u> , that I last saw the deceased alive on <u>February 10, 1957</u> , and that death occurred at <u>1:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas F. Dolan, Jr.</u> M.D.		DATE SIGNED <u>2-10-57</u>	
PHYSICIAN'S NAME (Type) <u>Thomas F. Dolan, Jr., M. D.</u>		ADDRESS (Street, city or town, state) <u>The Clinical Center National Institutes of Health Bethesda 14, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial - Transit</u>	<u>2/10/57</u>	<u>Woodlawn Memorial Park</u>	<u>Orlando, Florida</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>2-12-57</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

77

RECEIVED

1

INSTRUCTIONS

ENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be signed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

2027

02040

Reg. Dist. No. 214

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		STATE <u>Md.</u>		COUNTY <u>Prince Georges</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>None</u>		LENGTH OF STAY (in this place) <u>Since 7/1-57</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Deale</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Le Beau Gardens</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>SOPHIE SCHWARTZ</u>				4. DATE (Month) (Day) (Year) DEATH <u>July 1st 1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 9-1868</u>	9. AGE last birthday <u>88</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Abraham Wurman</u>				14. MOTHER'S MAIDEN NAME <u>Pauline Gurnavich</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mr. Max Schwartz, Deale Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
a. IMMEDIATE CAUSE (A) <u>Cerebral thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH			
b. ANTECEDENT CAUSE(S) DUE TO (B) <u>Dissecting aortic aneurysm R. ventricle</u>							
c. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerotic heart disease</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 14, 1955</u> , to <u>Feb 14, 1957</u> , that I last saw the deceased alive on <u>Feb 14, 1957</u> , and that death occurred at <u>9:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert J. Haddock, M.D.</u>		ADDRESS (Street, city, town, state) <u>10609 Concord St., Kensington, Md.</u>		DATE SIGNED <u>15 Feb 57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2/17/57</u>		NAME OF CEMETERY OR CREMATORY <u>National Hebrew Cemetery</u>		LOCATION (City, town, or county) <u>Washington, D.C.</u>	
24. REC'D BY REGISTRAR <u>Frances Celler</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Waldberg Funeral Home</u>		ADDRESS <u>4217-9th St. N.W.</u>	
DATE <u>2/20/57</u>							

RECEIVED

FEB 25 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02041

2026

CERTIFICATE OF DEATH

Reg. Dist. No 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 8 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 1519 Huntington Ave.,			
3. NAME OF DECEASED (Type or print) First George Middle Roy Last SHIBLEY				4. DATE OF DEATH Month February Day 12 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 Sept. 1886	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner & Policeman		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy & Gov't		11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Shibley				14. MOTHER'S MAIDEN NAME Florence Underwood			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-I		17. INFORMANT (Daughter) Mrs. Jean M. Shibley, 5003 Tuckerman		Address Riverdale, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of Cecum DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH 6-12 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. ft. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from 4 Feb. 1957 , to 12 Feb. 1957 , that I last saw the deceased alive on 12 Feb. 19 57 , and that death occurred at 12:00 Midnight , from the causes and on the date stated above.							
ACTUAL SIGNATURE Larry J. Hines		M.D. U.S. Naval Hospital, Bethesda, Md. 2-13-57					
PHYSICIAN'S NAME (Type) Larry J. Hines, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-18-57	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE Marlene Hysong				24a. REC'D BY REGISTRAR DATE 2-13-57		24b. REGISTRAR'S SIGNATURE Tracy L. Parrelly	

Page 1

BOHNS V. K.

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2028

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Md.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>3 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		d. STREET ADDRESS <u>11602 - ORchaugh S. Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy</u> First Middle Last <u>Smallwood</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 4, 1957</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <u>3</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Mont. Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Smallwood, Elmer E.</u>		14. MOTHER'S MAIDEN NAME <u>CARTER, Jean - (Mrs. Krumm)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Father</u>		Address <u>Above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Secondary causes (none)</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 1/2 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12 noon</u> , 1957, to <u>3 pm</u> , 1957, that I last saw the deceased alive on <u>2/25</u> , 1957, and that death occurred at <u>3:21 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul D. Cantor</u> M.D.		ADDRESS (Street, city or town, state) <u>4709 Montg. Lane, Bethesda, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Paul D. Cantor</u>		DATE SIGNED <u>4709 Montgomery Lane, Beth.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>2/26/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Pr. Geo. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR <u>2-26-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Dickinson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

1957

RECEIVED

1 INSTRUCTIONS TO ATTENDING PHYSICIAN HOSPITAL The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit. VS AISC 1-53 10M-

2029 CERTIFICATE OF DEATH

02042

Reg. Dist. No. 214

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		LENGTH OF STAY (in this place) <u>15 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
TOWN <u>Silver Spring</u>				TOWN <u>Silver Spring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1902 Rockwood Rd.</u>				STREET ADDRESS (If rural give location) <u>1902 Rockwood Rd.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Susan Conant Snow</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>FEB 22 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Aug 1, 1868</u>	
9. AGE last birthday <u>88</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Elizabeth, N. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Conant</u>				14. MOTHER'S MAIDEN NAME <u>Martha Wilson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT & ADDRESS <u>M. R. Snow 1902 Rockwood Rd. Silver Spring</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH -							
IMMEDIATE CAUSE (A) <u>Hypostatic Pneumonia</u>						4 days	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerotic Heart Disease</u>							
19a. DATE OF OPERATION <u>4-20-0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 7</u> , 19 <u>52</u> , to <u>Feb 22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 21</u> , 19 <u>57</u> , and that death occurred at <u>4:45</u> M., from the causes and on the date stated above.							
SIGNATURE <u>James B. Banchard</u> M.D.				DATE SIGNED <u>2/22/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>cremation</u>		DATE THEREOF <u>2/25/57</u>		NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory Princes Georges County</u>		LOCATION (City, town, or county) <u>Wash. DC</u>	
24. REC'D BY REGISTRAR <u>Frank Potter</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		ADDRESS <u>2901 14th St., N.W.</u>	

RECEIVED

FEB 25 1967

BUREAU V. S.

2030 CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>2-years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> MARYLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9303 Parkhill Terrace</u>				d. STREET ADDRESS <u>9303 Parkhill Terrace</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Fannie Archibald White Somerville</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>17</u> Year <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 23, 1876</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Archibald White</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Knowles</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Ida M. White</u>		Address <u>9303 Parkhill Terrace Bethesda Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1.0</u> DUE TO <u>Carcinosis of Liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> DUE TO <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>
21. I certify that I attended the deceased from <u>Sept 15, 1948</u> to <u>Feb 17, 1957</u> , that I last saw the deceased alive on <u>Feb 16, 1957</u> , and that death occurred at <u>2:45 PM</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arthur H. Lewis</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>1714 Rhode Island Ave N.W. 2-17-57</u>			
PHYSICIAN'S NAME (Type) <u>ARTHUR H. LEWIS</u>				<u>Washington 6 DC</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/19/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>				ADDRESS <u>2901 11th St. N.W. Washington 9, D.C.</u>		24. RECEIVED BY REGISTRAR <u>FEB 19 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Basie Thompson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02044

2031 CERTIFICATE OF DEATH

Reg. Dist. No. 2 17

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Prince George Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.F.D. Olney			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sharon Nursing Home				d. STREET ADDRESS Riggs Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Mary Middle Smith Last Sprowls				4. DATE OF DEATH Month Feb. Day 24 Year 19 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/27/1887	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington Co., Pa.	
						12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur Smith				14. MOTHER'S MAIDEN NAME Mary Paling			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. --		17. INFORMANT Address Nursing Home Records—R.F.D., Olney, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage Lower G.I. Tract 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Inoperable Co of sigmoid colon DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 5 days 2 yrs
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10 May , 19 52 to 23 Feb , 19 57 , that I last saw the deceased alive on 22 Feb , 19 57 , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE John B. Ziegler M.D. Olney, Md. 24 Feb 57 PHYSICIAN'S NAME (Type) JOHN B. ZIEGLER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/27/57		22c. NAME OF CEMETERY OR CREMATORY Geo. Washington Memorial Prince Georges Co., Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS The S.H. Hines Co. 2901 14th St., N.W. F				24a. REC'D BY REGISTRAR DATE 27 1957		24b. REGISTRAR'S SIGNATURE Gertude Lawler	

BUREAU V. S.

FEB 27 1957

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2032 CERTIFICATE OF DEATH

Reg. Dist. No.

24

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2. KENSINGTON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON GARDENS - SANITARIUM				d. STREET ADDRESS 13723 DUPONT AVENUE			
3. NAME OF DECEASED (Type or print) First Middle Last Jenora MASON Stone				4. DATE OF DEATH Feb 14, 1957			
5. SEX F	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 13, 1876	9. AGE (In years last birthday) 80 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jenoras Fleming				14. MOTHER'S MAIDEN NAME Glorinda Cheney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO none		17. INFORMANT Mrs. Evelyn B. Richardson, Warren Green Hotel Warrenton, Virginia			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure 4:00 DUE TO Arteriosclerosis, Sclerotic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility (c) Senility						INTERVAL BETWEEN ONSET AND DEATH 1 month yr yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1956 to Feb 13, 1957 , that I last saw the deceased alive on Feb 14, 1957 , and that death occurred at 4:50 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Allen			ADDRESS (Street, city or town, state) 10,407 Fawcett St., Kensington, Md.				
DATE SIGNED 2/14/57			DATE SIGNED 2/14/57				
PHYSICIAN'S NAME (Type) SAMUEL ALLEN							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/16/57	22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY MD.		
23. FUNERAL DIRECTOR'S SIGNATURE Abner C. Humphrey			ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR 2/16/57		
					24b. REGISTRAR'S SIGNATURE Frances Eiler		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

20

BUREAU V. S.

FEB 19 1957

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2033 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt #1 Rockville x Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) <u>Florence Katherine Surber</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 13 1913</u>	
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min <u>4</u>		IF UNDER 24 HRS Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min <u>4</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>		11. BIRTHPLACE (State or foreign country) <u>United States</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT <u>Alfred Surber</u>				Address <u>Rt #1 Rockville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line (or (a), (b) and (c)).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute disseminated lupus erythematosus</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Terminal pulmonary edema</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. g. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>2-15</u> , 19 <u>57</u> , to <u>2-25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-25</u> , 19 <u>57</u> , and that death occurred at <u>104 Cherry Chase Dr.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>104 Cherry Chase Dr.</u> DATE SIGNED <u>2/26/57</u>							
ACTUAL SIGNATURE <u>George A. Gray, Jr.</u> M.D. <u>Cherry Chase 15, Md.</u>							
PHYSICIAN'S NAME (Type) <u>George A. Gray, Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/26/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda</u>				ADDRESS <u>Bethesda</u>		24a. REC'D BY REGISTRAR <u>2-25-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
MAR 1 1957
BUREAU V. 3

2034 CERTIFICATE OF DEATH

Reg. Dist. No.

02047
216

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>XXXX D.C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Rest Home</u>				d. STREET ADDRESS <u>3917 Military Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLARD R. SWINOLE</u>				4. DATE OF DEATH Month <u>02</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 15, 1885</u>		9. AGE (In years last birthday) yrs <u>71</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Gov't.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auditor</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Robert Duncan Swinole</u>				14. MOTHER'S MAIDEN NAME <u>Emma Johnston</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Marion A. Clark, 3917 Military Rd., N.W., D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exfoliating dermatitis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Common heart disease</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Common heart disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 19, 1957</u> , to <u>Feb 20, 1957</u> , that I last saw the deceased alive on <u>Feb 20, 1957</u> , and that death occurred at <u>9:15</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. Joseph Kenrick</u>		ADDRESS (Street, city or town, state) <u>6450 Wisconsin Ave, Bethesda, Md.</u> DATE SIGNED <u>Feb 20/1957</u>					
PHYSICIAN'S NAME (Type) <u>DR JOSEPH KENRICK</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>Feb 23, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Catharine's Memorial Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chung Chan Funeral Home</u>		ADDRESS <u>5103 Newington</u>		REC'D BY REGISTRAR <u>2400 D.C.</u>		DATE <u>2-27-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
MAR 1 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2035 CERTIFICATE OF DEATH

02048
216

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 14, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 47x-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>		d. STREET ADDRESS <u>1226 - 6th Street, N. W.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>Inez</u> Middle <u>(none)</u> Last <u>Taylor</u>		4. DATE OF DEATH Month <u>February</u> Day <u>26</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 20, 1905</u>
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles Smith</u>		14. MOTHER'S MAIDEN NAME <u>Mary Crowley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>The Medical Record</u>		Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchial pneumonia - Bilateral</u> <u>171X</u> DUE TO <u>pneumal effusions</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Emphysema - severe secondary</u> DUE TO <u>To Carcinoma of Cervix such</u> (c) <u>metastases</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>October 14, 1956</u> , to <u>February 26, 1957</u> , that I last saw the deceased alive on <u>February 26, 1957</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chester Z. Haverback</u> M.D.		The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) <u>C</u> <u>Chester Z. Haverback, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-2-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wheaton</u>	22d. LOCATION (City, town, or county) (State) <u>Washington</u> <u>DC</u>
23 FUNERAL DIRECTOR'S SIGNATURE <u>Frazier's Funeral Home</u>		24a. REC'D BY REGISTRAR <u>WAR 1</u> 1957	
ADDRESS <u>389 R L Ave</u>		24b. REGISTRAR'S SIGNATURE <u>Reed Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
MAR 1 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2036 CERTIFICATE OF DEATH

02049

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Virginia b. COUNTY Alexandria			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 38 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 402 Hume Avenue			
3. NAME OF DECEASED (Type or print) First Fred Middle Clifton Last Terrell				4. DATE OF DEATH Month February Day 5 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH January 3, 1894		9. AGE (In years last birthday) yrs. 63	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operating Engineer			10b. KIND OF BUSINESS OR INDUSTRY Powder Plant		11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Luther Terrell				14. MOTHER'S MAIDEN NAME Rebecca Crenshaw			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO 458-10-6637		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma, left lung 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) adenocarcinoma, rectum metastatic to him DUE TO (c) Prostate carcinoma of prostate gland.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. 9 p. m. Month, Day, Year 19 57			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from December 29, 19 56 to February 5, 19 57 , that I last saw the deceased alive on February 5, 19 57 , and that death occurred at 12:50 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE James R. Stabenau M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 2/5/56			
PHYSICIAN'S NAME (Type) James R. Stabenau, M. D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 2/17/57		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C. Okla.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers				24a. REC'D BY REGISTRAR PER 11		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

RECEIVED

FEB 11 195

BUREAU V.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03519

CERTIFICATE OF DEATH

02050

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Alabama b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Birmingham	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 12 Montrose Circle	
3. NAME OF DECEASED (Type or print) First Earl Middle Calvin Last Thorn		4. DATE OF DEATH Month February Day 6 Year 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 3, 1921
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor (Investments)		10b. KIND OF BUSINESS OR INDUSTRY Insurance	9. AGE (In years last birthday) 35 yrs
11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James M. Thorn		14. MOTHER'S MAIDEN NAME Bessie Cox	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis DUE TO (c) hypertension			INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. 7. Month 19 Day 19 Year 19 p. m.	20d. INJURY OCCURRED White <input type="checkbox"/> Nat while at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 15, 1957 to February 6, 1957 , that I last saw the deceased alive on February 6, 1957 , and that death occurred at 11:40 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Gurston. Goldin, M. D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type)		DATE SIGNED 2/6/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2-7-57	22c. NAME OF CEMETERY OR CREMATORY ELMWOOD	22d. LOCATION (City, town, or county) (State) BIRMINGHAM, ALA.
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Chambers Co. 1400 Chapin St NW		24a. REC'D BY REGISTRAR DATE - 8-57	24b. REGISTRAR'S SIGNATURE Bessie M. Thompson

U. S. A.

1957

RECEIVED

2037 CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring 4 Mo</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>11104 Snood Ave.</i>		d. STREET ADDRESS <i>7981 New Riggs Rd</i>	
3. NAME OF DECEASED (Type or print) First <i>Rhea</i> Middle <i>Rebecca</i> Last <i>Topas</i>		4. DATE OF DEATH Month <i>Feb</i> Day <i>3</i> Year <i>1957</i>	
5. SEX <i>F.</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/26-1902</i>
9. AGE (In years last birthday) <i>54</i> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Great Britain</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Solomon Rosenbloom</i>	
14. MOTHER'S MAIDEN NAME <i>Sola Zelde Shuket</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>219-26-2201</i>		17. INFORMANT <i>Joseph Topas</i> Address <i>7981 New Riggs Rd</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Congestive failure</i> DUE TO <i>Secondary anemia, Malnutrition</i> DUE TO <i>Carcinomatous of abdomen</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>2 months</i> <i>7 months</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>9/8</i> , 19 <i>56</i> , to <i>2/3</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>2/2</i> , 19 <i>57</i> , and that death occurred at <i>8 a m</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Eino Magi</i>		ADDRESS (Street, city or town, state) <i>8401 University Lane</i> DATE SIGNED <i>2/3/57</i>	
PHYSICIAN'S NAME (Type) <i>EINO MAGI</i>		Silver Spring, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>2/4-1956</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Net Mem Park</i>	22d. LOCATION (City, town, or county) (State) <i>Falls Church Va</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Goldberg Funeral Home</i> ADDRESS <i>1004 28th St</i>		24a. REC'D BY REGISTRAR <i>1957</i>	24b. REGISTRAR'S SIGNATURE <i>Frances Potter</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is retained by the hospital or attending physician.

TO REGISTAR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 6 1957

RECEIVED

CERTIFICATE OF DEATH

1927

Reg. Dist. No.

773

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Maryland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg, Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u>				d. STREET ADDRESS <u>5300 Tilden Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Lloyd</u> Middle <u>Samuel</u> Last <u>Truax</u>				4. DATE OF DEATH Month <u>February</u> Day <u>23</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-12-77</u>	
9. AGE (In years last birthday) <u>79</u> yrs		IF UNDER 1 YEAR Months <u>5</u> Days <u>11</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rail Road Brakeman</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>American-USA</u>							
13. FATHER'S NAME <u>Samuel Truax</u> (TRUAX)				14. MOTHER'S MAIDEN NAME <u>Not Known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Patient's Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ischemic stroke</u> <u>103x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Renal Insufficiency</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>congestive heart failure</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>May 1956</u> to <u>Feb 23, 1957</u> that I last saw the deceased alive on <u>Feb 23, 1957</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. M. Zerbit</u> M.D.				DATE SIGNED <u>2-23-57</u>			
PHYSICIAN'S NAME (Type) <u>Takoma Park, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/26/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARK HEIGHTS CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BRUNSWICK, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Merton W. Hyon</u>				24a. REC'D BY REGISTRAR <u>1300-N. St. NW</u>			
24b. REGISTRAR'S SIGNATURE <u>Wash. State, D.C.</u>				DATE <u>FEB 25 1957</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 25 1957

BUREAU V.

2038

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>11260 Old Bladensburg Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>MARGARET Elizabeth TRUCKS</u>		4. DATE OF DEATH <u>2-9-1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-30-1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William BARNES</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET CLARK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Annette Johnson (niece)</u>		Address <u>35, Md. 11260 Old Bladensburg Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> (c) <u>Marked generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple meningioma</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/12</u> , 19 <u>57</u> , to <u>2/9</u> , 19 <u>57</u> that I last saw the deceased alive on <u>Feb 9</u> , 19 <u>57</u> , and that death occurred at <u>10:45 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Marion Bankhead</u>		ADDRESS (Street, city or town, state) <u>9241 Col. Blvd</u>	
PHYSICIAN'S NAME (Type) <u>J. Marion Bankhead Silver Spring Md</u>		DATE SIGNED <u>2/9/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb 12, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St John's Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		ADDRESS <u>8431 Georgia Ave. Silver Spring</u>	
24a. REC'D BY REGISTRAR <u>2-12-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1957



1957

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BUREAU V. S.

FEB 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2040 CERTIFICATE OF DEATH

02055

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE [Where deceased lived. If institution Residence before admission] o. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
c. LENGTH OF STAY IN 1b 22 Days				d. STREET ADDRESS 1802 Bay St., S.E.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Clarence Middle (nmn) Last TYLER				4. DATE OF DEATH Month February Day 28 Year 19 57			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 July 1896	9. AGE (In years lost birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Doorman (Garfinkle's Department Store)				10b. KIND OF BUSINESS OR INDUSTRY Virginia		11. BIRTHPLACE (State or foreign country) U.S.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Joseph Tyler				14. MOTHER'S MAIDEN NAME Jennie Harlings			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-I		17. INFORMANT Official Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma esophagus with metastases 100X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH NINE MONTHS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6 Feb. 19 57 , to 28 Feb. 19 57 , that I last saw the deceased alive on 28 Feb. 19 57 , and that death occurred at 6:00A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE James E. McClenathan Lcdr		M.D. U.S. Naval Hospital, Bethesda, Md. 2-28-57					
PHYSICIAN'S NAME (Type) James E. McClenathan, LCDR, MC, USN		U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4 March 1957		22c. NAME OF CEMETERY OR CREMATORY 1st Baptist Church Cemetery, Amherst, Virginia		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W.E. Jarvis				24a. REC'D BY REGISTRAR DATE 2-28-57		24b. REGISTRAR'S SIGNATURE Ray E. Carrelly	

REAU V. S.

1957

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02056 214

Reg. Dist. No.

2041

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. LENGTH OF STAY IN 1b 4 years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9701 Conn. Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle O. Last VARN				4. DATE OF DEATH Month Feb. Day 3, Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 18, 1907	9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months 2 Days 15	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newspaper (Treas. Nat'l. Assoc. Press)			10b. KIND OF BUSINESS OR INDUSTRY South Carolina		12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME (Press Club) William H. Varn			14. MOTHER'S MAIDEN NAME Lula Catherine Oxner				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 057-10-2780		17. INFORMANT Louise Varn-wife		Address Item #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. 19 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Feb. 3, 1957			
EXAMINER'S NAME (Type) Frank J. Broschart,		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 6, 1957	22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	22d. LOCATION (City, town, or county) (State) Montgomery County, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE Warner C. Humphrey			ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR 7/57	24b. REGISTRAR'S SIGNATURE Frances Teller	

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FEB 11 1957
J. A. BROWN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02057

2042

CERTIFICATE OF DEATH

Reg. Dist. No. 764

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11717 Highview Ave.			d. STREET ADDRESS 11717 Highview Ave.		
3. NAME OF DECEASED (Type or print) Carrie Etta Varney			4. DATE OF DEATH February 4, 1957		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/21/61	9. AGE (In years and birthday) 95 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lebanon, Maine	
13. FATHER'S NAME Alexander Corson			14. MOTHER'S MAIDEN NAME Mary E. Tibbetts		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Helen Varney 11717 Highview Ave. S.S.Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebro-vascular Renal Disease DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 10 Days 5 Yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from Feb 3 , 1957, to Feb 4 , 1957, that I last saw the deceased alive on Feb 3 , 1957, and that death occurred at 8 A M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Harold Heiger		ADDRESS (Street, city or town, state) 1835 Eycost NW DATE SIGNED 2/4/57			
PHYSICIAN'S NAME (Type) Harold Heiger MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) removal	22b. DATE THEREOF 2/5/57	22c. NAME OF CEMETERY OR CREMATORY Cold Spring Cemetery	22d. LOCATION (City, town, or county) (State) East Rochester, New Hampshire		
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. Washington, D.C.		24a. REC'D BY REGISTRAR FEB 6 1957	24b. REGISTRAR'S SIGNATURE Frances P. Talley		

BUREAU V. E.

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2043

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 13 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8003 EASTERN AVENUE		e. STREET ADDRESS 8003 EASTERN AVENUE	
3. NAME OF DECEASED (Type or print) First MABEL Middle CELIA Last VAUGHAN		4. DATE OF DEATH Month FEB. Day 25 Year 19 57	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/1/72
9. AGE (In years last birthday) 84 yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOT-MAKER - OWN HOME		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME RAYNOR F. BARHAM	
14. MOTHER'S MAIDEN NAME REBECCA T. JUDKINS		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mrs. Ruth V. Keefe, 8003 Eastern Ave., Apt. 304 Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from Nov. 19 52 , to Feb 25 , 19 57 , that I last saw the deceased alive on Feb 24 , 19 57 , and that death occurred at 7⁴⁵ A.M. , from the causes and on the date stated above.	
ACTUAL SIGNATURE Lawrence J. Thomas M.D.		ADDRESS (Street, city or town, state) 900 17th St N.W. DATE SIGNED	
PHYSICIAN'S NAME (Type) LAWRENCE J. THOMAS			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2/27/57	22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY	22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR 28 51	24b. REGISTRAR'S SIGNATURE

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MAR 2-1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02059

Reg. Dist. No. 214

2044							
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			c. LENGTH OF STAY IN 1b <u>7 months</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9604 MT. PISGAH ROAD</u>				d. STREET ADDRESS <u>9604 MT. PISGAH ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>ANDREW</u> Last <u>WAITE</u>				4. DATE OF DEATH Month <u>FEB.</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/9/77</u>		9. AGE (In years last birthday) <u>79</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer - retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Andrew Waite</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>028-10-3665</u>		17. INFORMANT Address <u>Mr. Don A. Waite, 9604 Mt. Pisgah Road Silver Spring, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHART</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		<u>FEB. 11, 1957</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/13/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wash. Nat'l. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wanner & Humphrey</u>				ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>2/16/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Frances J. Lister</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please extend the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STANDARD V. S.

FEB 19 1957

RECEIVED

2045
CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY <u>Montg</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> c. LENGTH OF STAY IN 1b <u>20 Yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> d. STREET ADDRESS <u>1000 N. ...</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph</u> <u>Horace</u> <u>Wear</u>		4. DATE OF DEATH Month Day Year <u>Feb</u> <u>17</u> <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 2-1901</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min <u>0</u> <u>1</u> <u>0</u> <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone Repairman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Telephone Repairman</u>	
11. BIRTHPLACE (State or foreign country) <u>Petersburg Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph J. Wear</u>		14. MOTHER'S MAIDEN NAME <u>Emma C. Wood</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-09-1086</u>	
17. INFORMANT <u>Margaret L. Wear</u>		Address <u>Bel Air, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>January 24, 1956</u> , to <u>February 17, 1957</u> , that I last saw the deceased alive on <u>February 12, 1957</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James P. Kerr</u> PHYSICIAN'S NAME (Type) <u>James P. Kerr</u>		ADDRESS (Street, city or town, state) <u>Bel Air, Md.</u> DATE SIGNED <u>2/18/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>2-19-57</u>	<u>Park Lawn</u>	<u>Bel Air, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Cartner</u>		ADDRESS <u>Bel Air, Md.</u> 24a. REC'D BY REGISTRAR DATE <u>2-19-57</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles L. Cooke</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 25 1967

BUREAU V. S.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairland Nursing Home</u>		c. LENGTH OF STAY IN 1b <u>2 wks</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R-2 Silver Spring</u>		e. STREET ADDRESS <u>6802 Georgia St.</u>	
3. NAME OF DECEASED (Type or print) <u>Sarah Ellen Wood</u>		4. DATE OF DEATH Month <u>2</u> Day <u>8</u> Year <u>1957</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-12-62</u>
9. AGE (In years last birthday) <u>94</u> yrs.		10. IF UNDER 1 YEAR Months <u>94</u> Days <u>19</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		12. KIND OF BUSINESS OR INDUSTRY <u>va</u>	
13. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. FATHER'S NAME <u>Wesley Wood</u>		16. MOTHER'S MAIDEN NAME <u>Mildred Ann Cropp</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <input type="checkbox"/>		18. SOCIAL SECURITY NO. <u>Nursing Home Records</u>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac failure</u> <u>40 d.d.</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Chronic myocarditis</u> (c) <u>4 mo</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>40 d.d.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 mo</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>2-8-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>Feb. 11, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Orlean Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Orlean, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u>		24. REC'D BY REGISTRAR <u>FEB 13 1957</u>	
25. ADDRESS <u>2901 14th St. N.W. Washington 9, D.C.</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files of the funeral director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STAN Y. S.

FEB 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02062

2047

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Alabama</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Max-3 Vredenburgh</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Daisy</u> Middle <u>Beatrice</u> Last <u>Young</u>				4. DATE OF DEATH Month <u>February</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>31 December 1931</u>	
9. AGE (In years last birthday) <u>25</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>21</u> Hours <u>—</u> Min. <u>—</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Alabama</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Bush Albert Threadgill</u>				14. MOTHER'S MAIDEN NAME <u>Leota Maness</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>19-38-9827</u>		17. INFORMANT <u>The Medical Record, Clinical Center</u> <u>National Institutes of Health, Bethesda 14, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> <u>754.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARDIAC SURGERY</u> DUE TO (c) <u>VENTRICULAR SEPTAL DEFECT</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>25 1/2</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Renal Failure, CNS Damage, Thrombocytopenia</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. 11</u> Month <u>19</u> Day <u>19</u> Year <u>1957</u> p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u>				(County) <u>—</u>		(State) <u>—</u>	
21. I certify that I attended the deceased from <u>10 February, 1957</u> , to <u>22 February, 1957</u> , that I last saw the deceased alive on <u>22 February</u> , 1957, and that death occurred at <u>2:14 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theodore Cooper</u>				ADDRESS (Street, city or town, state) <u>The Clinical Center</u> <u>National Institutes of Health</u> <u>Bethesda 14, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Theodore Cooper, M. D.</u>				DATE SIGNED <u>2/23/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur. Transit 2/23/57</u>		22b. DATE THEREOF <u>2/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Tunnel Springs Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Monroeville, Alabama</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>2-23-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

BUREAU V. S.

FEB 28 1957

RECEIVED

2048

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CRESTVIEW-</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CRESTVIEW</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4902 CRESCENT</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>PAUL</u> Middle <u>C.</u> Last <u>ZIEHL</u>				4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>2</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 2 1882</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>QUARTERMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OIL LIST Co.</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Edward Ziehl</u>		14. MOTHER'S MAIDEN NAME <u>Thelma Zammie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>MARY ANN ZIEHL 4902 CRESCENT</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease -</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>1953</u> , 19 <u>—</u> , to <u>February-2 1957</u> , that I last saw the deceased alive on <u>February 1</u> , 19 <u>57</u> , and that death occurred at <u>5:30</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>22-1957 DATE SIGNED</u>							
ACTUAL SIGNATURE <u>Irene G. Tamagna</u> M.D. <u>7101 CONNECTICUT AVE CHCH., 15th</u>				PHYSICIAN'S NAME (Type) <u>IRENE G. TAMAGNA</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>FEB. 5 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>SUITLAND, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Don DeVol</u>				ADDRESS <u>2224 WIS AVE. D.C.</u>		24a. REC'D BY REGISTRAR <u>2-5-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filled in by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 7 1957

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